PREA Facility Audit Report: Final

Name of Facility: Stevenson House Detention Center
Facility Type: Juvenile
Date Interim Report Submitted: NA
Date Final Report Submitted: 08/10/2021

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Tammy A. Hardy-Kesler	**Date of Signature:** 08/10/2021

AUDITOR INFORMATION	
Auditor name:	Hardy-Kesler, Tammy
Email:	codyemomma@msn.com
Start Date of On-Site Audit:	02/15/2021
End Date of On-Site Audit:	02/17/2021

FACILITY INFORMATION	
Facility name:	Stevenson House Detention Center
Facility physical address:	750 North DuPont Boulevard, Milford, Delaware - 19963
Facility Phone	
Facility mailing address:	

Primary Contact	
Name:	Kevin Solomon
Email Address:	kevin.solomon@delaware.gov
Telephone Number:	302-424-8100

Superintendent/Director/Administrator	
Name:	Katherine Kenney
Email Address:	katherine.kenney@delaware.gov
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Facility PREA Compliance Manager	
Name:	Sean Harris
Email Address:	sean.harris@delaware.gov
Telephone Number:	O: (302) 424-8113

Facility Characteristics	
Designed facility capacity:	55
Current population of facility:	17
Average daily population for the past 12 months:	16
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Both females and males
Age range of population:	12-20
Facility security levels/resident custody levels:	Level 5
Number of staff currently employed at the facility who may have contact with residents:	80
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	9
Number of volunteers who have contact with residents, currently authorized to enter the facility:	6

AGENCY INFORMATION	
Name of agency:	Delaware Division of Youth Rehabilitative Services
Governing authority or parent agency (if applicable):	Department of Children, Youth And Their Families
Physical Address:	1825 Faulkland Road , Wilmington , Delaware - 19805
Mailing Address:	
Telephone number:	302-633-2620

Agency Chief Executive Officer Information:	
Name:	John Stevenson
Email Address:	John.Stevenson@delaware.gov
Telephone Number:	302-633-2620

Agency-Wide PREA Coordinator Information			
Name:	Danielle Stevenson	**Email Address:**	danielle.stevenson@delaware.gov

AUDIT FINDINGS

Narrative:
The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Prison Rape Elimination Act onsite audit was conducted at the Stevenson House Detention Center located in Milford, Delaware on February 15-17, 2021. The audit was completed by the audit team of TAHK Consultants lead by Tammy A. Hardy-Kesler a U.S. Department of Justice juvenile auditor and Kimberly Napier a U.S. Department of Justice adult auditor. The Stevenson House Detention Center is in the jurisdiction of Delaware State's child welfare agency, the Delaware Department of Services for Children, Youth, and Their Families (DSCYF). Operations of the Stevenson House Detention Center is maintained by the Division of Youth and Rehabilitative Services (DYRS). Contract procurement for the PREA audit was executed and finalized on May 14, 2020. The previous onsite PREA audit was completed April 2-4, 2018. The designated PREA auditor was Tammy A. Hardy-Kesler of TAHK Consultants. The final PREA Report was signed on July 18, 2018 which certified that the facility was in full compliance of all PREA standards.

There were barriers which occurred during the pre-onsite and onsite audit phase that impeded the auditors, DSCYF, DYRS, and the Stevenson House Detention Center during the audit process. There were unprecedented barriers caused by Covid-19 Pandemic that impacted the PREA onsite audit. Additionally, to decrease the spread of Covid-19, DYRS along with other juvenile residential facilities across the country implemented precautions to prevent spread and where possible remote working schedules for employees. The Stevenson House Detention Center is the Covid-19 hub for all the DYRS state operated facilities. Youth from all 4 facilities are housed at Stevenson House Detention Center if they are found to be Covid-19 positive.

Pre-Onsite Audit Phase

From previous experience with other DYRS PREA audits, the PREA coordinator and the lead auditor agreed in utilizing the Online Audit System (OAS). Prior to the onsite audit on February 1, 2021, there was a transition to a new PREA coordinator. The PREA coordinator quickly became familiar with the operations of the OAS. The PREA coordinator became acquainted with the system's ability to maintain and share secured information between all parties. The auditors were granted access to the pre-audit questionnaire (PAQ) on January 4, 2021. Prior to the onsite audit, supplemental files were continuously uploaded by the PREA coordinator on the request of the auditors.

The final set of onsite audit dates were established on October 12, 2020. The auditor provided a table with due dates for onsite audit (2/15-2/17, 2021), posting of audit notice in the facility (12/21/2018), deadline for PAQ (1/4/2021) and the date for interim/final report (4/3/2021). Time stamped photos with locations of audit postings on light green paper reflected 12/28/2020 which was 7 weeks prior to the onsite audit. Auditors were provided time stamped photographs of audit postings through the OAS in the supplemental files. Delay of posting was due to Covid related barrier in which auditors requested an extension of audit posting until 3/15/2021 which was also attributed to the limited number of postings within the facility.

Further, logistical information was discussed on January 24-25, 2021 which included locations of opening and closing meeting, interview locations, onsite review of facility, document review, and issue log (documents needed) dissemination. Since DYRS had scheduled three audits within a 5-month period of time any required documents needed were provided in their entirety prior to the first audit. On November 2, 2020, PREA coordinator was provided with audit postings for all three facilities being audited. Postings were in both English and Spanish with instruction for date of posting and documentation necessary to confirm posting of audit notice.

On January 29, 2021, the PREA coordinator was provided the issue log (documents needed) which were to be addressed and returned to the auditors by 2/5/2021. Documents requested were either in the category of upload into supplemental files and the list of documents and footage to provide onsite. Items requested for supplemental upload were made available on 2/11/2021. Items requested for onsite audit were to be provided on 2/15/2021 at 10:00 a.m. The following information was requested in issue log (documents needed):

- List of staff
- List of New Hires within the past 12 months
- List of newly promoted within the last 12 months.
- List of youth
- List of contractors and volunteers with contact information
- List of youth receiving special education services.
- List of identified youth that represented targeted groups.
- Staffing Plan
- Training rosters for youth, staff, volunteers, and contractors
- Clarification to policies and procedures
- List and documents of allegations of sexual abuse and sexual harassment
- Dates of criminal background checks and child abuse registry consult

- Diagram of camera locations
- List of youth residing in facility over 72 hours, 10 days, and over 6 months.
- Copies of grievances

On 2/8/2021, the auditors received communication from Just Detention International, which indicated that there were no cases of sexual harassment or sexual abuse reported for the Stevenson House Detention Center.

The audit method utilized was practice based, and it adhered to requirements outlined by the 2nd edition of the Auditors Handbook which was released 3/1/2021. The auditors utilized observation of practice, random document review of resident and staff files, investigation files, review of policies and procedures, and interviews of specialized staff, volunteers, contractors, random staff, and random youth.

On 12/13/2020, both auditors reviewed the DYRS website. The site included the following:

- Federal PREA statutes and policy links
- DYRS PREA Policy link
- Agency PREA contacts
- National PREA resource links
- Statewide victim advocate contact information along with 24-hour confidential voice mail
- Survey of Sexual Victimization Reports from 2008 until 2019
- Final PREA Reports for the DYRS operated facilities.
- DYRS PREA Annual Reports from 2012 to 2019.

To establish the availability of SANE/SAFE examiners, on 2/14/2021 the auditors visited and interviewed the coordinator for SANE/SAFE at the Bayhealth Hospital-Sussex. The auditors were demonstrated the process a youth of Stevenson House Detention Center would experience during a forensic examination. It was found that SANE/SAFE examiners are available 24-hours at the hospital.

There was a system check by the auditors to the Child Abuse Hotline on 12/8/2020. The hotline directed callers to call 911 due to higher-than-normal call volume. Additionally, callers were directed to two email addresses.

After the onsite audit, there was a teleconference interview scheduled on 2/23/2021 with Survivors of Abuse in Recovery (SOAR). It is a statewide recovery program which provides counseling, referral, and education services to adult, adolescent and child survivors of sexual abuse and assault. Based on the interview, there is no interaction beyond an established Memorandum of Understanding between the agencies. SOAR shared that there is interest in providing workshops within the facility.

During the four weeks prior to the onsite audit, the auditor checked the post office box for youth, staff, or third-party correspondence regarding PREA at the Stevenson House Detention Center. The postal box was checked on 1/19/2021, 1/26/2021, 2/4/2021, 2/9/2021, 2/23/2021, 3/3/2021, 3/9/2021, 3/16/2021, 3/22/2021, and 3/30/2021. All dates netted no correspondence from youth, staff, nor third-party.

Onsite Audit

The onsite audit for the Stevenson House Detention Center was scheduled 2/15-2/16/2021. The auditors arrived on 2/15/2021 at 8:30 a.m. Upon entering the facility, the auditors observed there was a copy of the audit posting on light green paper. The auditors were required to sign in and out of visitor's log. Due to the Covid-19 Pandemic and Delaware State mandates, the auditors were required to have a mask. Additionally, the screening process included temperature checks and completion of a verbal Covid-19 questionnaire. Both auditors were cleared for entrance into the facility.

The auditors were accommodated in a large conference/training room within the administrative section of the facility. The room was utilized by the auditors as a base for the entire three days of the onsite audit. It was large enough that it provided adequate spacing between the auditors and the meeting attendees for the opening and closing meetings. The auditors were able to have at least a 12 feet distance from interviewed specialized and random staff. Also, the room was conducive for conducting confidential interviews. There was an opening meeting at 9:00 a.m. on 2/5/2021 with Deputy Director, PREA coordinator, Superintendent, and the PREA compliance manager. During the meeting, there were introductions and a discussion of the audit process. There was a brief discussion regarding the impact of the agency-wide corrective actions at the recent audit at the Residential Cottages (12/16-12/18/2020) would also be reflected on the Stevenson House Detention Center's audit. There was a brief discussion on the audit process due to transition of the new PREA coordinator. Additionally, plans for the closing meeting was finalized.

The auditors conducted interviews of agency leadership, administration, specialized staff, random staff, random youth, targeted youth, volunteers, and contractors. The protocols utilized were from the U.S. Department of Justice Bureau of Justice Assistance and additional questions. There were two locations provided to conduct interviews. The auditors interviewed random staff in the administrative wing in the front of the building. Youth were interviewed in the library. Both interview areas provided were conducive to conducting confidential interviews. Also held in the administrative conference room were several specialized staff interviews held via teleconference. Additionally, there were some interviews that were held after the onsite audit.

In advance, the PREA coordinator scheduled meetings with all agency-wide staff during the first day of onsite audit. Due to the Covid-19 Pandemic, agency-wide staff work a remote schedule. There were instances in which telephone was relied upon to complete interviews of

specialized staff. The following agency-wide staff were interviewed:

- Deputy Director designee for the Agency Head
- Statewide Juvenile PREA Coordinator
- Agency Contract Administrator for Out of State Residential Providers
- Institutional abuse investigator
- Management analyst
- Human resource manager
- Mental health supervisor
- Criminal Background Unit
- Internal Affairs
- Hotline Administrator
- Training Director

The management analyst was interviewed via teleconference. During the audit of the Residential Cottages (12/16-12/18/2020), there was an opportunity to review records storage. The records storage was a two-lock system. Also, there was a review of the agency-wide database, FOCUS which encompasses all facets of youth information involved in DSCYF. This database allows for access based on level of employment category to avoid exploitation of resident's information. The auditors were given a hands-on tutorial of the capabilities of the FOCUS database.

During the first day of onsite audit, the PREA compliance manager provided the auditors the following onsite or by uploading to supplemental files:

- Resident population list.
- Staff roster indicating dates of criminal background checks and child abuse registry consult.
- Roster of employees that were hired within the last 12 months.
- List of New Hires within the past 12 months.
- List of newly promoted within the last 12 months.
- List of contractors and volunteers with contact information.
- Dates of criminal background checks and child abuse registry consult.
- Diagram of camera locations.
- List of youth residing in facility over 72 hours, 10 days, and over 6 months.
- Copies of the allegations of sexual harassment and sexual abuse.

During the remainder of the onsite audit, the auditors were provided:

- Thumb Drive containing footage of intake.
- Footage of PREA rounds.
- PREA Risk Assessments.
- List of youth receiving special education services.
- Training rosters for staff.
- Copies of grievances.
- 2 Mock Incident Reviews.
- Curriculum for volunteers and contractors.

Due to Covid-19, the auditors conducted the site review in two phases over the three days so that all areas internal and external could be reviewed. The auditors were escorted by the superintendent and the PREA compliance manager. On the first day of the onsite audit, the auditors viewed Unit F the Covid Unit. While the unit had been professionally fogged and treated the youth were temporarily moved to Unit C. The youth diagnosed with Covid were transferred back to Unit F after the site review. After youth were transferred back to the unit, the corridors were treated and fogged. Unit C was viewed from attached corridor and further review was completed via Central Control. All medical and mental health treatment for youth diagnosed or quarantined is provided directly on the unit. Additionally, auditors site reviewed the medical and mental health suite. Located within the corridors are cameras. Also, any physical exams are conducted with 2 personnel, and a custody staff outside of the door. Any forensic examinations would be completed offsite at Bayhealth Hospital, Sussex Campus which has SANE/SAFE.

On the second day of onsite audit, the auditors arrived at 5:00 a.m., the auditors completed sign in process, and completed the Covid-19 screening process. The entire second day of the onsite audit was dedicated to interviewing random staff, random youth, targeted youth, and the remainder of specialized staff. Due to the Covid-19 Pandemic, random staff interviews were selected based on availability during the shifts at the Stevenson House Detention Center. During the random youth and targeted youth interviews, the facility was in supervision of 31 youth. Of those 31 youth, there were 5 quarantined and 8 diagnosed with Covid-19. The youth medical status was confirmed through medical records, facility administration, and medical personnel.

To ensure that staff from all 3 shifts were interviewed the auditors conducted interviews until 11:50 p.m. on 2/16/2021. The following

interviews were conducted:

- 18 Random youth
- 13 Random staff
- 8 Targeted youth
- Higher level or intermediate staff
- Food service staff
- Mailroom staff
- Grievance and disciplinary staff
- Medical staff
- Maintenance staff
- Union representative
- Superintendent
- Mental health staff
- Intake staff
- Retaliation Monitor
- Facility PREA Investigator

Auditors were made aware that 2 additional youth were admitted, and they were diagnosed with Covid-19. They were being transferred from the New Castle County Detention Center. Auditors were unable to do an in-person review of intake, but the facility provided the auditors with the footage of both intakes.

On the third day of the onsite audit 2/17/2021, the auditors arrived at 8:30 a.m. The auditors adhered to the protocols of the facility by signing in and completing the Covid-19 screening process. The third day of the audit was designated for file review and the completion of the site review. Waiting until the last day of the audit gave the facility adequate time to sanitize remaining areas due to the Covid diagnosed youth transferring back to Unit F. Auditors were informed that the facility was selected as the Covid Hub due to the design of the facility. The design of the facility prevented cross contamination of staff and youth. The Covid unit and the quarantine unit were in close proximity to the admission area. Youth or staff designated to those units could easily access unit from the intake entrance of the facility.

The facility site review included all areas including internal areas, external areas, and central control camera review. The facility had very good sight lines. On the second phase of the onsite review the auditors were escorted by the PREA compliance manager.

Stevenson House Detention Center has 6 housing units consisting of 2 large housing units and 4 smaller housing units. The housing units are identified alphabetically A-F. There is one unit that is designated for females which is Housing Unit B, and at the time of the onsite audit, there were no female youth at the facility. Unit E is utilized as a game room for youth that earn the privilege through the Cognitive Behavior Therapy. At this time Unit F is housing youth diagnosed with Covid-19. Housing Unit A is utilized as a quarantine unit.

Centralized on all of the housing units is the activity area. Branching from the activity area is staff offices, staff restroom, and youth bathrooms. In the rear of each housing unit is the outdoor recreation area. All youth bathrooms on the housing units are designed the same. Housed within the restroom is both the shower and the toilet. Youth are required to dress and undress within the confines of the bathroom area. The bathrooms are secured by a door, and they can only be accessed by a key. No cameras were able to view youth showering or toileting. The facility only has single cells on housing units, and at least one wet room per housing unit.

During the site review, there was a system's check of the telephones. The phones were centralized in the activity areas of the housing units. All phones in the housing units were operable, but the information listed on the phones was incorrect. The youth would have difficulty contacting the Child Abuse Hotline to report sexual harassment and sexual abuse. The PREA compliance manager begin correcting telephone information during the onsite audit. The auditor performed an internal system check of the telephone system. Once the child abuse hotline was contacted, the lead auditor left a message for the dispatcher's administrator. During the interview with the administrator of the hotline, it was mentioned that the message was received.

Youth are provided recreation either outside of housing units or in the gymnasium. The gymnasium is located towards the front of the building. Youth are required to use bathrooms in the outside hallway of the gymnasium. Additionally, the gymnasium has access to an outside recreation area. There is a bathroom in the outside recreation area of the gymnasium, but according to the PREA compliance manager, youth are escorted to the hallway bathroom.

Next to the gymnasium is the visitation area. This area was utilized for visitation prior to Covid-19. Youth maintain contact with family and legal representatives through virtual means such as Facetime and Zoom. There are 3 sections to this area. There is a more private visitation area along the side which allows for meetings with legal representation which provides a means of confidentiality. There is clear sight into each individual area from the main visitation area. Then there is the main visitation area which has tables and chairs set up for visitation. At this time, the main area is utilized to distribute PPE to staff that do not work in areas with quarantined youth or youth diagnosed with Covid-19. The third section of this area is utilized as a canteen distribution area. Canteen is distributed based on student's progress in the Cognitive Behavior Therapy (CBT). All sections are equipped with cameras.

Across the hall from the gymnasium and the visitation area is the cafeteria. The kitchen and the cafeteria are separated. Youth do not have

access to the kitchen area. Youth are served all meals in the cafeteria unless they are on quarantine or diagnosed Covid-19. The kitchen area has several sections which include dry storage and freezer areas. Behind the kitchen area is the laundry area and the loading dock. In the loading area, there is the maintenance area. The maintenance workers are not solely for the facility. They service other local state buildings as well. In order to access areas within the kitchen and beyond there is swipe access. There is no work detail at the facility that youth participate in according to the maintenance supervisor and kitchen supervisor.

Further down the long corridor is the library. In the library, the bookcases are against the walls for easy visual within the room. Down from the library is the education suite. Housed in the area is a working area for teachers and instructional assistants. Also, there are offices for the educational leader, educational support staff, and related service staff. Attached to each housing unit are classrooms. During the onsite audit, youth were receiving education on a hybrid schedule due to Covid-19 limitations. Youth were receiving both in-person and virtual learning. Classrooms were equipped with up-to-date technology which included SmartBoards. All rooms were equipped with cameras.

Central Control is located in the front of the facility. During the A shift and B shift, there are 2 officers, and on the C shift, there is 1 officer. There are 2 desks with 3 monitors each.

During the onsite review of the facility, the auditors found no areas where youth were held in isolation. There was limited and inconsistent PREA related postings within the facility. There were postings at each unit reminding opposite gender to announce when entering the facility. There were no units that had the victim advocacy information.

Locations of resident grievance boxes were shown to the auditors. There was a grievance box located at all but one housing unit of the Stevenson House Detention Center. There were forms and writing utensils at each grievance box. The PREA compliance manager explained that the facility no longer uses the green Emergency PREA Grievance, but there is only a white form that is utilized. According to PREA compliance manager, a PREA related grievance would not continue through the normal grievance process, but It would be immediately handled in accordance to DYRS Policy 2.13.

During the onsite audit, the lead auditor had limited informal conversations with youth and staff due to the impact of Covid-19. The few conversations with youth gleaned that they felt safe from sexual harassment and sexual abuse. Youth assured the auditors that under the circumstances of Covid-19 that there was opportunity to communicate by telephone or virtually with family members, attorneys, and outside agencies. Staff disclosed to the auditor that Covid-19 has impacted the facility.

After the site review, the auditors continued to review files. Documents reviewed included:

- Youth Files
- Staff Files
- Medical Files
- Logs
- Volunteer and Contractor Files

The auditors reviewed 11 active youth files. There was a combination of files reviewed from residents across the 3 open units due to the inability to interview Covid diagnosed and quarantined youth. In total there were 12 employee files selected. Every eighth person on the staff roster was selected for file review. Also, the same selection process was utilized to select three of the files of the 17 new hires within the last 12 months. Additionally, there were two files selected of the five employee files of promoted staff within the last 12 months. Auditors reviewed 4 volunteer files. There were no contractor files made available. There were limited files available due to the volunteer/contractor coordinator being transferred to the position within the last 12 months. The auditors were able to determine during the file review of both youth and staff that most information is maintained in the FOCUS database, the Learning Center database or at the Criminal Background Unit Office.

The closing meeting for the onsite portion of the audit was completed at 3:30 p.m. on 2/17/2021. The meeting participants were present in person and teleconference. The meeting was scheduled by the PREA coordinator. In attendance were the auditors, deputy director via teleconference, superintendent, assistant superintendent, PREA coordinator via teleconference, PREA compliance manager, and the volunteer/contractor coordinator. The auditors noted that youth were familiar on reporting allegations of sexual abuse and sexual harassment. Also, there was a brief discussion of mock incident reviews. The auditors thanked the Stevenson House Detention Center for their dedication to sexual safety in confinement.

Post Onsite

There were remaining interviews that were conducted by telephone after the onsite visit.

- Two volunteers 3/5/2021
- Three contractors 3/5/2021
- Milford Police Department 2/26/2021
- SOARS 2/23/2021

After the onsite audit, a teleconference interview with the external investigative body, Milford Police Department was conducted on 2/26/2021 at 10 a.m. During the interview, the auditor determined that there were possibly 2 allegations of sexual abuse that needed further

research.

The auditor requested that the PREA compliance manager maintain the audit postings until 3/24/2021. The auditor made the request due to the limited number of audit postings through the building. Due to Covid-19, many youth may not have had an opportunity to review the audit postings.

Additional documentation and a reminder was requested by auditor via email on 2/21/2021 and 2/27/2021. The facility provided documentation requested through the OAS supplemental files.

During the post onsite review, it was determined by the auditors that within the last 12 months there were no sexual abuse or sexual harassment allegations. It was further confirmed by the Milford Police Department. There were 2 sexual abuse allegations that were reported from Stevenson House Detention Center to the Milford Police Department. It should be noted the allegations originated in the community and at a contracted facility.

The facility provided 2 mock incident reviews of sexual abuse and sexual harassment allegations from 2/13/2020 and 1/21/2021.

The management analyst provided documentation of allegations of sexual abuse and sexual harassment since the last PREA audit. There was 1 sexual abuse allegation in 2018. The allegation was resident on resident. Contained in the investigative file there was a non-critical report, sexual violence incident forms, an email of screening by Institutional Abuse, and Notification of Investigation Status Form. There was documentation of discipline and separation of youth. The investigation lacked victim statement, copy of grievance, witness statements, perpetrator statement, investigative summary, and the copy of footage. There was documentation that stated that the allegation was screened out by Institutional Abuse. There was no incident review conducted by the facility. It should be noted that youth were no longer at facility to further interview regarding their allegations of sexual abuse. The documentation stated that the allegation was unsubstantiated.

At the time of the onsite audit, the auditors were able to determine that there were no cases in progress according to IA, the PREA facility investigator, and the management analyst. It was further confirmed by the Milford Police Department there were no criminal cases of sexual abuse or sexual harassment cases in progress from the Stevenson House Detention Center.

There was inquiry of both the Residential Cottages and Stevenson House Detention Center regarding the ability to provide interpretation/language services. It was further assessed on 1/8/2021. Through the PAQ, a copy of the contract for interpretation/language services through the Government Support Services Office of Management and Budget. Provided with the contract was a list of service providers. The lead auditor selected a language provider and a sign language provider. The language provider verified that services had been provided to the Residential Cottages. The sign language provider explained the process in which the Stevenson House Detention Center would obtain services either virtually or onsite for sign language.

On 3/14/2021, there was an in-depth search of the internet for information pertaining to the Stevenson House Detention Center. During the internet search of the Stevenson House Detention Center, the auditors were not able to locate any information on litigation specific to the facility neither was there any U.S. Department of Justice involvement cited on the internet. There were news articles, press clippings, and televised news reports captured regarding the impact of Covid-19 on both the staff and youth at Stevenson House Detention Center.

On 2/23/2021, SOARS had a combination Zoom and teleconference with the auditors. Due to meeting a month earlier for the Residential Cottage’s audit, SOARS reconfirmed being a victim advocacy agency. SOARS reiterated there was an established memorandum of understanding which outlined the services that were available to youth of the Stevenson House Detention Center. The agency is not a reporting agency but stated if there was an instance in which an incident of sexual abuse or sexual harassment occurred to a juvenile, the agency is mandated to report to the Child Abuse Hotline.

Auditors reviewed interviews that were completed during all phases of the audit. In total there were 82 interviews conducted, and there were 63 interviews required by the Auditors Handbook. There were 43 specialized staff interviewed, and there were 13 random staff, 18 random youth, and 8 targeted youth interviewed. There were several staff members and youth that had multiple roles covered by the protocols. The Stevenson House Detention Center employs 74 staff members which does not include administrative staff.

Positions Employed at the Stevenson House Detention Center

Youth Rehabilitative Counselor Supervisor- 8

Youth Rehabilitative Counselor I- 24

Youth Rehabilitative Counselor II-25

Youth Rehabilitative Counselor III-3

Food Service Supervisor-1

Food Service Specialist I-2

Laundry Worker- 1

Food Specialist II- 2

Food Specialist CS- 1

Custodial Worker- 1

Family Crisis Therapist- 1

Volunteer Services Coordinator- 1

Recreation Program Leader- 1

AS II- 1

MA I- 1

Admin I- 1

Based on the roster provided by the PREA compliance manager there were 17 new employees within the last 12 months. During the onsite audit, there were 13 random staff interviews conducted.

On the first day of the onsite audit, there were 31 youth at the Stevenson House Detention Center. On the same day, there were 3 releases. On the following day, there were two additional admissions transferred from NCCDC diagnosed with Covid-19. According to the Auditor's Handbook, at least 10 random youth are required to be interviewed for facilities that have under 50 youth. On 2/16/2021, the auditors interviewed 18 random youth, and 8 targeted youth. Once completed admissions, the youth are either housed in Covid-19 unit or the admission's quarantine unit for 14 days.

The Stevenson House Detention Center has 6 volunteers. All volunteers were contacted for teleconference. Two volunteers returned auditor's call and were interviewed. In the case of the contractors, there were 9 contractors identified by the facility on the PAQ. The auditor contacted 3 of the contractors, and there were three contractors who returned the auditor's call and were interviewed.

At the time of the onsite audit, there were 8 youth that represented a targeted group. There were no youth identified in the PAQ nor in the reviewed PREA Risk Assessments. During the interview with a specialized staff, the auditors determined that there were 8 youth that were receiving special education services for their disabilities. The auditors review of resident files and resident interviews did not indicate any youth that were representative of any other targeted groups. Specifically, there were no youth that reported sexual abuse. There were no youth that were limited English proficient. The 18 youth that were interviewed did not disclose being identified as transgender, intersex, gay, or bisexual. Stevenson House Detention Center does not have an isolation area so there were no youth identified as being in isolation. There were no barriers to identifying targeted groups. Utilizing the FOCUS Database would allow for easier tracking and data collection of the targeted groups within the DYRS facilities.

The auditors completed an onsite audit of documentation which included personnel files, resident files, PREA risk assessments, and investigative files. Every eighth employee on the roster was selected for the documentation review. There were 12 personnel files selected. Onsite employee files lacked PREA training information and criminal history information. It was found that this information is maintained at the criminal history unit and the PREA training information was maintained in the Learning Center's database. PREA training information, criminal history, and child abuse consult information was provided on rosters.

There were 11 resident files reviewed. Out of the 11 residential files selected, there were 2 files that were inactive. There was limited PREA training information contained in files. In 6 of the resident folders, there was no evidence of PREA information given during the intake process. In 7 of the 11 residential files, there was no evidence of comprehensive training which takes place within 10 days of intake. Additionally, the auditors were provided 22 PREA Risk Assessments of current youth in the facility. The auditors were able to determine demographic information and date of admission from resident files and resident roster. Additionally, emails generated by FOCUS after risk assessment is completed were also provided to auditors. Emails are generated to notify building level administrators to assist in classifying youth into particular housing units with correct supervision.

AUDIT FINDINGS

Facility Characteristics:
The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate or resident population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Delaware Department of Services for Children, Youth and Their Families (DSCYF) has the jurisdiction of facilities operated by the Division of Youth Rehabilitative Services (DYRS). The DSCYF Campus is located in the suburbs of Wilmington, Delaware. The Stevenson House Detention Center is a security level V facility located in Milford, Delaware. The facility is one of four juvenile facilities operated by DYRS. The other facilities are the Ferris School for Boys (FSB), New Castle County Juvenile Detention Center (NCCDC) and the Residential Cottages (RC) which are located on the DSCYF Campus.

The Delaware County Courts specifically the Kent and Sussex Family Courts place adjudicated male and female youth at the Stevenson House Detention Center. Youth served at the facility are between the ages of 12-20 years old. The facility capacity is 55 youth. There are six housing units that comprise the Stevenson House Detention Center. The housing units are identified alphabetically from A-F. There are four housing units and two larger housing units. Housing Unit A serves pre-adjudicated females, and the other housing units serve pre-adjudicated males. Within the last 12 months, there have been 159 youth detained at the detention center. The daily average of residents was 16. The average length of stay was 38 days.

On the first day of the onsite audit, the total population for the Stevenson House Detention Center was 31 males. There were 28 African American/Non-Hispanic or Latino males,1 White/Hispanic male or Latino, and 2 White/Non-Hispanic or Latino males ranging in the ages of 12-18 years old. Youth were admitted to the Stevenson House Detention Center between the dates of 1/22/2020 to 2/14/2021.

On the first day of the onsite audit, there were 74 staff members employed at the Stevenson House Detention Center. All staff are trained to work with both male and female youth in the housing units. Staff can be interchanged between the housing units as well as throughout DYRS facilities. The interchange of staff was prevalent throughout the Covid-19 Pandemic. To ensure appropriate ratios during the pandemic, staff was shared amongst the other juvenile facilities on the DSCYF Campus. According to the Pre- Audit Questionnaire (PAQ), were 15 new employees within the last 12 months.

Listed on the PAQ and the roster provided during the onsite audit, Stevenson House Detention Center has 9 contractors that provide direct services to residents at the facility. Those contracts include medical care, dental service, barber, yoga, pet therapy and Life Skills. Additionally, the facility has 6 volunteers that provide direct services to the residents. Volunteer services included Christian Ministry and Islamic Services.

Movement within the entire building is controlled by swipe access or key. Throughout the facility including the administrative wing, housing units, classrooms, cafeteria, medical/mental health suites are monitored by 77 cameras. The auditors identified cameras in the visitation area, classrooms, cafeteria, hallways, and the exterior of the facility. During the onsite review, all cameras were operable. Youth bathrooms throughout the facility comprised of an individualized unit with a toilet and shower secured with a door. The door could only be opened by staff from the outside, and residents were able to exit on their own. Youth are to disrobe and dress within the confines of the bathroom configuration. This practice was further confirmed during random youth interviews. Youth could not be viewed showering or toileting by the cameras in any of the housing units. This was further confirmed during the site review of central control. All telephones were operable, but postings and signage throughout the building that had incorrect telephone information will need to be corrected. The PREA compliance manager made necessary corrections to the information during the onsite audit.

During the first day of onsite audit, the facility was housing residents in Unit A, Unit D, and Unit F. To be prepared for additional Covid diagnosed youth from NCCDC, Unit C was moved to Unit F. The auditors were able to verify through medical records and a distant site review, the units that were both Covid diagnosed and quarantined youth. Additionally, the auditors viewed the units via cameras.

Lobby/Administration/Staff Lounge Area

Upon entrance into the Stevenson House Detention Center, there were copies of the auditor postings on light green paper in both English and Spanish. The entrance way is monitored by 2 cameras, and within the lobby there are 2 additional cameras. Opposite the lobby is the administrative offices and staff lounge area. To access this area, a swipe card is needed. There are 2 cameras that monitor the hallways of the administrative and staff lounge area. The staff lounge area is comprised of the staff locker room, dining room area, and staff restrooms. In the administrative area, there is a conference room, staff offices, and file storage. The conference room was the base for the auditors during the onsite audit.

Gymnasium/Outside Recreation Yard

The gymnasium is located towards the front of the facility. The area is monitored by 2 cameras. There are gym equipment storage closets off the gym floor. There is a youth bathroom inside the gym, but the practice has been that youth are escorted to the youth bathroom located outside of the gym in the hallway. The outdoor recreation area has 2 cameras monitoring. There is a bathroom located outside in the outdoor recreation area. The auditors were informed that youth are not allowed to use the outdoor bathrooms, and they must be

escorted back into the building to the youth bathroom located across the main corridor from the gymnasium. During the onsite review, the auditor found the outside bathroom to be unlocked.

Cafeteria/Kitchen

The cafeteria is located towards the front of the facility, and it is accessible from the main corridor. There is a cement boundary around the cafeteria. The dining area is monitored by 2 cameras. During meals, there are 2 to 3 staff supervising, and youth are permitted to sit no more than 2 youth at a table. There is no staff dining in the cafeteria/kitchen area. Staff are provided an area for food consumption in the staff lounge. Youth are not allowed access behind the serving area of the cafeteria. Meals are prepared at the facility by kitchen staff. There are no residents on work detail in the kitchen. Behind the food serving line is a full commercial kitchen. There are no cameras located in the kitchen area. Within the kitchen area, there are coolers, freezers, dry good area, dish room, paper storage, chemical room, kitchen laundry room, supervisor office, staff office, and 2 staff restrooms.

Laundry/Maintenance Area/ Loading Dock

Accessible from the kitchen is the laundry area, maintenance area, and loading dock. The laundry area consists of commercial washers and dryers and folding area. This area is not accessible to youth, and there is no work detail by youth in this area. There are no cameras in this area.

In close proximity of the laundry area is the sallyport which leads to the loading dock and maintenance area. Comprised in the area is locked cage storage, archived storage, janitor's closet, and staff restroom. The maintenance area is within the vicinity of the loading dock. There is a locker room, warehouse, and 2 offices. There is no youth work detail in the maintenance area.

Medical/Mental Health Suite

Medical and Mental Health Services are provided in the Medical and Mental Health Suite. Medical calls and medication are provided in this area except for Covid-19 diagnosed and quarantined youth. The suite also includes a dental lab. Forensic medical examinations would be provided at Bayhealth Hospital Sussex Campus. There are 2 cameras that monitor the hallways in the medical suite. There are youth and staff restrooms. There was 1 PREA related poster, but there were no audit postings. The medical suite has 2 examination rooms, medical file room, dental lab and storage rooms, medication dispensary closet, storage room, 2 mental health offices, and 1 nursing supervisor's office. During informal conversation with medical personnel, it was found that during physical examinations that there must be 2 medical personnel present for examinations. The hours of operation for medical personnel was 7:00 a.m. to 7:30 p.m. If necessary, there is an on-call doctor available.

Visitation

Located near the front entrance of the facility, there is a visitation area. Due to the Covid-19 Pandemic, onsite family visitation and attorney visitation has been suspended. According to both staff and residents, regular weekly virtual visitations and telephone calls are made available for both family and attorneys. The visitation area has three sections. There is a large visitation area primarily used for family visits. Off to the side of the main visitation area is a smaller visitation area that is primarily used for confidential meetings mostly attorney meetings. This area is highly visible, but it provides a level of privacy to have a confidential meeting. The last section of the visitation area is used for the distribution of commissary earned from the Cognitive Behavior Therapy Program (CBT). All areas of the visitation area can be accessed by camera.

Education

Located towards the front of the facility is the education suite. The suite is comprised of 3 offices. The education office is not accessible to youth, and there are no cameras located within the suite. The area houses the education administrator, education related services staff, education support staff, and a teacher preparation area. There is a storage closet that gains access to the library. Classrooms are located further in the facility. Each housing unit has classrooms which can be accessed from either the housing unit and the main corridor. Youth move to the classes according to the class schedule. During the pandemic, the facility has been operating on a hybrid schedule of virtual and in-person instruction. During the onsite audit, the auditors observed a class in session. Classrooms were equipped with SmartBoards. Youth are provided an educational program equivalent to the curriculum received at a traditional school setting.

Library

Next to the education suite is the library. The library is accessible from the main corridor as well as through a storage area attached to the education suite. There are 2 cameras monitoring the area. The bookshelves are against the walls which makes for easy visibility. There were 2 PREA signs located at the corridor entrance. In addition, there was the auditors notice that were in both English and Spanish. Also, there was a sign with the Child Abuse Hotline number of 1-800-292-9582. The room is utilized to provide youth programming, testing, and virtual visits to their families.

Housing Unit A

At the time of onsite audit, this unit was utilized for new admitted youth that were required to quarantine for 14 days. Auditors were able to view unit from a distance in order to prevent possible transmission of Covid-19. Additionally, the unit was observed from Central Control.

The unit in a prior audit was not utilized for housing. The unit was utilized for additional storage space. At the time of the audit, there were 6 male youth housed on the unit.

Housing Unit B

This unit is utilized to house female youth. At the time of the onsite review, there were no female youth housed on the unit. The unit has the capacity to hold up to 10 youth. One of the cells on the unit is a wet room. There is 1 classroom that is attached to this unit and can be accessed from the main corridor. The classroom has 1 camera. This unit has a total of 4 cameras monitoring the unit, and there are 2 cameras monitoring the outside recreation area. None of the cameras can view youth while toileting or showering. There was no PREA information posted on the unit. The auditor's notice was posted in both English and Spanish. There was signage for opposite gender staff to announce presence. In the activity area, the auditors located 2 operable telephones which needed correct information to contact the Child Abuse Hotline. No victim advocacy contact information was available. Found on the unit was a box, but it was not identified as a grievance box. The unit housed 2 staff offices and a staff bathroom. There was no isolation on the unit.

Housing Unit C

The unit is designated as a male unit. This unit was designated for Covid diagnosed youth. During the first day of the onsite audit, there were 8 male youth housed on the unit. On the afternoon of the first day of the audit, the residents of this unit were relocated to Unit F. During the third day of the onsite audit, the unit was being decontaminated. The auditors were able to view the unit from a distance. It was further reviewed in Central Control. This precaution was taken to prevent the spread of Covid-19. The unit has 2 classrooms attached with both having a camera, and both classrooms can be accessed from the unit as well as the main corridor.

Housing Unit D

This unit is one of the 2 largest housing units at the Stevenson House Detention Center. This unit has the capacity to house 22 youth. The unit is designated as a male unit. During the onsite audit, there were 18 male youth housed on the unit. The unit has 2 classrooms attached with both having a camera. Both classrooms also have access to the main corridor. Located were 2 operable telephones which needed corrected Child Abuse Hotline information. The auditor's notice was posted in both English and Spanish on light green paper. At the entrance, there was signage reminding the opposite gender staff to announce prior to entering. The housing unit was monitored by 4 cameras on the housing unit, and 2 cameras on the outside recreation area. In total, there were 4 youth bathrooms and 1 staff bathroom. There were 2 staff offices which consisted of a supervisor office and a staff office. There was a grievance box located with both regular grievances and PREA Emergency Grievance Forms. There was no isolation on the unit.

Housing Unit E

This unit has the capacity to house 5 youth. It is no longer utilized as a housing unit. At this time, the unit is utilized as an incentive area for youth that excel in the Cognitive Behavior Therapy Program (CBT). Within the existing activity area is gym equipment as well as televisions with gaming systems. There is 1 youth bathroom and 1 staff bathroom. There are 2 operating telephones which need corrected hotline information and victim advocacy information. There was a grievance box located on the unit. Auditors located the auditor notice posted in the unit both in English and Spanish. The unit is monitored by 2 cameras, and there is 1 camera monitoring the outdoor recreation area. Attached are 2 classrooms in which one is being utilized for offices due to Covid. Both classrooms are accessible to the main corridor. There was no isolation on the unit.

Housing Unit F/Intake Unit

Prior to Covid, the housing unit was not occupied. At this time, the housing unit is being utilized for Covid diagnosed males. The unit has one floor, and it can house up to 7 youth. Prior to Covid, the unit was not being utilized. For opposite gender staff, there was signage upon entrance indicating to knock and announce prior to entering. The unit consisted of the activity area, program manager office, and staff offices, 7 single cells, youth bathroom and a staff bathroom. One of the cells was a wet room.

Posters pertaining to PREA were removed off the wall due to the Covid sanitation process of fogging the unit.

There were 2 cameras on the housing unit, and there were 2 cameras externally in the outside recreation area of the housing unit.

There were 2 telephones in the activity area that could be utilized to call the Child Abuse Hotline. There was a sign informing residents of the information to contact the Child Abuse Hotline. The sign will have to be changed to reflect correct contact information. There were no victim advocacy contact information located on the housing unit. Though the phone was found operable, the information on the telephone for the Child Abuse Hotline was incorrect. There was no isolation on the unit. Auditors were able to view staff in full PPE during the onsite review of cameras in central control.

There is a vestibule that is between Unit F and Intake. Intake is located towards the rear left of the facility. This area has an entrance. This area was utilized for staff to enter and exit who supervised Covid diagnosed unit and quarantine unit. Staff would dress and disrobe full PPE in this area to prevent contamination throughout the facility. The intake area is comprised of a video conference room, laundry designated for intake, interview room, staff restroom, youth bathroom, storage room, 2 holding cells, Office of Family Engagement, 2 search/shower rooms, and storage for youth uniform and hygiene supplies. There were 2 intakes that occurred during the onsite audit. Both intakes were Covid diagnosed transfers from New Castle Detention Center. Auditors were provided video footage of intake due to limiting

the possibility of Covid transmission. According to the PREA compliance manager, residents are provided an orientation to PREA. Residents are asked to sign acknowledgement of receiving information during intake, and the information is placed in youth's folder.

There was no grievance box located on the unit. The auditors were informed that there would be a grievance box placed on the unit.

Central Control/Cameras

Within Central Control, there are 2 desks with 3 surveillance monitors on each desk. According to the PREA compliance manager, there are two staff posted in Central Control during A and B shift. During C shift, there is 1 staff posted in Central Control. Auditors were able to view all cameras. There were no cameras offline during the onsite review. There were cameras that would benefit from upgrades due to blind spots that were discovered by the auditors.

The camera system was manufactured by Honeywell. There is an existing service agreement in place with Advance Tech to provide maintenance services. There were 77 cameras in total.

The cameras have the capability of recording feeds for up to 90 days. There was an upgrade to the camera system which allows for a longer retrieval of camera footage. This was the only enhancement that occurred since the last PREA onsite audit.

Programs/Services

The Stevenson House Detention Center offer the following to youth:

- Education Program
- Transition/Aftercare Services
- Individual and Family Counseling
- Daily academic education by certified instructors, special education services and GED preparation
- Mental Health services provided by a certified psychologist and psychiatrist.
- Life Skills Curriculum
- Medical, dental, and eye care services
- Programming offered by various community partners such as yoga and pet therapy
- Cognitive Behavior Therapy (CBT) – The Stevenson House Detention Center's behavior modification program

AUDIT FINDINGS

Summary of Audit Findings:
The OAS will automatically calculate the number of standards exceeded, number of standards met, and the number of standards not met based on the auditor's compliance determinations. If relevant, the auditor should provide the list of standards exceeded and/or the list of standards not met (e.g. Standards Exceeded: 115.xx, 115.xx..., Standards Not Met: 115.yy, 115.yy). Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	1
Number of standards met:	42
Number of standards not met:	0

Standard	**Ttile**	**Overall Determination**
Prevention Planning		
115.311	Zero Tolerance	Meets Standard
115.312	Contracts	Exceeds Standard
115.313	Supervision/Staffing	Meets Standard
115.315	Cross Gender Viewing & Searches	Meets Standard
115.316	Residents with Disabilities and LEP	Meets Standard
115.317	Hiring and Promotions	Meets Standard
115.318	Upgrades to Facilities and Technologies	Meets Standard
Responsive Planning		
115.321	Evidence Protocol/Forensic Medical Examinations	Meets Standard
115.322	Policies to Ensure Referrals of Allegiations	Meets Standard
Training and Education		
115.331	Employee Training	Meets Standard
115.332	Volunteer and Contract Training	Meets Standard
115.333	Resident Education	Meets Standard
115.334	Specialized Training: Investigations	Meets Standard
115.335	Specialized Training: Medical and Mental Health Care	Meets Standard
Screening for Risk		
115.341	Obtaining Information from Residents	Meets Standard
115.342	Placement of Residents	Meets Standard
Reporting		
115.351	Resident Reporting	Meets Standard
115.352	Exhaustion of Administrative Remedies	Meets Standard
115.353	Resident Access to Outside Confidential	Meets Standard

	Support Services and Legal representation	
115.354	Third-Party Reporting	Meets Standard
Official Response Following A Resident Report		
115.361	Staff and Agency Reporting Duties	Meets Standard
115.362	Agency Protection Duties	Meets Standard
115.363	Reporting to Other Confinement Facilites	Meets Standard
115.364	Staff First responder Duties	Meets Standard
115.365	Coordinated Response	Meets Standard
115.366	Preservation of Ability to Protect Residents from Contact with Abuser	Meets Standard
115.367	Agency Protection Against Retaliation	Meets Standard
115.368	Post-Allegation Protective Custody	Meets Standard
Investigations		
115.371	Criminal and Administrative Agency Investigations	Meets Standard
115.372	Evidentiary Standard for Administrative Investigations	Meets Standard
115.373	Reporting to Residents	Meets Standard
Discipline		
115.376	Disciplinary Sanctions for Staff	Meets Standard
115.377	Corrective Action for Contractors and Volunteers	Meets Standard
115.378	Interventions and Discipllinary Sanctions for Residents	Meets Standard
Medical and Mental Care		
115.381	Medical and Mental Health Screenings: History of Sexual Abuse	Meets Standard
115.382	Access to Emergency Medical and Mental Health Services	Meets Standard
115.383	Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers	Meets Standard
Data Collection and Review		
115.386	Sexual Abuse Inceident Reviews	Meets Standard
115.387	Data Collection	Meets Standard
115.388	Data Review Corrective Action	Meets Standard
115.389	Data Storage, Publication, and Destruction	Meets Standard
Auditing and Corrective Action		
115.401	Frequency and Scope	Meets Standard

115.403	Audit Contents and Findings	Meets Standard

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act (PREA) (Revised 6/29/17). 2. Youth Rehabilitative Services Director's Office Organizational Chart (Effective 2/25/19). 3. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA Compliance Managers Organizational Chart. 4. State of Delaware Employee Performance Plan PREA Coordinator Section I, B (pp. 2), (2/11/21). 5. Stevenson House Detention Center Organizational Chart (Effective 4/2020). 6. Pre-Audit Questionnaire (PAQ) 7. Director's Team Meeting Minutes (8/7/2020) 8. Stevenson House Detention Center Resident Handbook (pp. 3-4) (Revised June 2010) Interviews: 1. PREA coordinator 2. PREA compliance manager 3. Site Review Observations: Observation of the PREA compliance manager performing duties on facility grounds Findings (by Provision): 115.311 (a) 1-4: 1. The agency has a written policy mandating zero-tolerance against all forms of sexual abuse and sexual harassment. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, section II titled Policy, (pp.1-3) establishes zero-tolerance for any incidence of sexual activity with youth, sexual abuse and sexual harassment. Any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth including consensual is criminal and prohibited. All matters that involve the allegation of any sexual contact will be reported to the child abuse hotline. This applies to all staff which includes department employee, volunteer, contractor, official visitor or other agency representatives. The Stevenson House Detention Center Resident Handbook page 3 and 4, outlines prevention, intervention, self-protection, reporting sexual abuse, treatment and counseling. The resident handbook briefly mentions that the facility has a policy that does not allow for sexual activity but does not mention the agency's zero-tolerance policy mandating zero-tolerance against all forms of sexual abuse and sexual harassment. 2. Agency Policy 2.13 (DYRS) Prisoner Rape Elimination Act, Section IV outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The agency's policy outlines prevention of sexual abuse and sexual harassment through the designation of a PREA coordinator and PREA compliance manager, resident PREA orientation, resident handbook, resident intake screening, risk assessments, PREA postings, resident education, housing placement, program assignments, movement throughout the facility, criminal history background checks of employees, contractors, and volunteers, staff PREA training and staff supervision. The policy outlines detection of sexual abuse and sexual harassment through supervisory staff unannounced rounds, staff announcement of the opposite gender in the housing unit, resident handbook, intake screening for residents, risk assessments, and PREA training for staff. The agency's policy addressed responding to sexual abuse and sexual harassment through resident and staff reporting, resident handbook, child abuse hotline, emergency PREA grievance, investigations, disciplinary action, terminations and or criminal prosecution, medical and mental health treatment, incident review team, victim services, community emotional support services, and data collection. This policy provides and outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment. 3. Policy 2.13 III, Section II, B Definitions (pp.1-3), defines non-consensual sexual act or abusive sexual contact as contact with any person with or without his or her consent or of a person who is unable to consent or refuse. DYRS policy establishes that contact between the penis and the vagina or the penis and the anus, including penetration, however slight; contact between the mouth and the penis, vagina, or anus; penetration of the anal or genital opening or another person, by a hand, finger, or other object; intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person. The policy does not define Voyeurism as a definition of sexual abuse. The policy combines the sexual abuse definitions for both youth and staff which negates parts of the definitions as required in

the PREA standards definition 115.6. It should read, “Sexual abuse of a resident by another resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse.

a) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;

b) Contact between the mouth and the penis, vulva, or anus;

c) Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, another instrument; and

d) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

It should read, “Sexual abuse of a resident by a staff member, contractor, volunteer includes any of the following acts with or without consent of the resident.

a) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;

b) Contact between the mouth and the penis, vulva, or anus;

c) Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse or gratify sexual desire;

d) Penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

e) Any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

f) Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)-(5) of this section;

g) Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of a resident and

h) Voyeurism by a staff member, contractor, or volunteer.

The policy does not include the definition of “Voyeurism by a staff member, contractor, or volunteer as outlined by PREA standards definition 115.6.

4. Policy 2.13 Section III, Definitions Titled Sexual Harassment (page 2), combines the sexual harassment definitions for both youth and staff which negates parts of the definitions as required in the PREA standards definition 115.6.

a. It should read “repeated and unwelcome sexual advances, request for sexual favors, or verbal comments, gestures or actions of a derogatory or offensive sexual nature by one resident directed towards another.

b. It should read “repeated verbal comments or gestures of a sexual nature to a resident by a staff member, contractor or volunteer including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

5. Agency policy 2.13 PREA Section IV C, D, E, includes sanctions of disciplinary action up to and including termination and/or criminal prosecution, and referral to the Delaware State Police for those found to have participated in prohibited behavior. Policy outlines discipline for residents via the cognitive behavior treatment (CBT) program.

115.311 (b) 1-3:

Agency policy 2.13 (DYRS) (PREA) Section III, D., Page two outlines the position of the PREA coordinator (PC). The policy provides that the PC acts as the agency representative on PREA related issues, attends national or regional PREA meetings, regional training opportunities and provides assistance to the PREA compliance managers (PCM). The PC will develop, implement and oversee the agency’s efforts to comply with the PREA standards in all facilities. In review of Pre-Audit Questionnaire (PAQ) and the DYRS Director’s Office organizational chart, the agency employs an upper-level agency-wide PREA coordinator that holds the position of Professional Standards Manager. The PC performance plan outlines that the Professional Standards Manager/PREA coordinator reports directly to the agency DYRS Director and provides assistance to the PREA compliance managers. The PREA coordinator reported she was just appointed to this position on 2/1/2021 a position held by the previous PREA coordinator since 01/07/19. The previous PREA coordinator was promoted to Deputy Director of the Division of Management Services on 1/4/21 and covered the PREA coordinator position until

2/1/21. During an interview, the PREA coordinator reported that she has sufficient time to manage PREA related responsibilities. The PC indicated she is new in her position but is working on audit preparation for the facilities and will meet quarterly with each PREA compliance manager on facility specific needs. In the PAQ, the PC provided agency documentation for the auditor's review. The PC demonstrated knowledge about her duties, agency policy, practices and efforts for compliance with the PREA standards.

The evidence shows that the agency has designated an upper-level agency-wide PREA coordinator which was verified through the agency policy, organizational chart, performance plan and interview with PC. The PC has worked in her position for the last month and has led the agency's efforts towards compliance with the PREA standards. In the Pre-Audit Questionnaire (PAQ), the PREA coordinator provided audit documentation, 14 subsequent file documentation, scheduled required interviews that demonstrated that the PC has sufficient time and authority to oversee the agency's efforts in complying with PREA.

115.311 (c): 1-4:

Agency policy 2.13 (DYRS) (PREA) Section III, D., Page 2 outlines the position of the PREA compliance manager (PCM). The policy provides that the PCM will ensure PREA compliance operationally and it's readiness for all related PREA standards. In review of the DYRS Stevenson House Detention Center Organizational chart, the facility has designated a PREA compliance manager that holds the position of Youth Rehabilitation Counselor Supervisor in the organizational structure and reports directly to the Assistant Superintendent. A review of the State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services PREA compliance managers Organizational Chart, the agency operates four facilities and has designated a PCM at each facility. During an interview, the PCM reported that he does have enough time as the PREA compliance manager and works A/B on a split shift and C shift every third weekend. The PCM reports that he works with the PREA coordinator in consultation with the Superintendent to comply with the PREA standards. In the PAQ, the PCM provided agency documentation as well as 11 supplemental files for the auditor's review. During the site review, the PCM escorted the auditors throughout the facility and his interactions with the facility staff and youth demonstrated knowledge about his duties, agency policy, practices and efforts for compliance with the PREA standards.

The evidence shows that the agency has designated a PREA compliance manager which was verified through the agency policy, organizational chart, and interview with the PCM. The PCM has worked his position for thirteen and a half years. The PCM is leading the facilities efforts to comply with the PREA standards.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Revise the PREA Policy 2.13, Section II titled Policy, to update the term "sexual activity" to "sexual abuse" as defined under PREA Standard definitions 115.6.
2. Revise the Stevenson House Detention Center Resident Handbook (pp. 3) to update the "sexual activity" to "sexual abuse" as defined under PREA Standard definitions 115.6 In addition include the agency's Zero-tolerance towards all forms of sexual abuse and sexual harassment.
3. Revise the PREA Policy 2.13, Section IV titled Procedures, to include a Detection and Response section so that the agency's approach is clearly outlined.
4. Revise PREA Policy 2.13. Section III titled Definitions (B and C), to clearly define sexual abuse definitions for resident by another resident and resident by staff as required in the PREA standards definition 115.6. It does not have to read verbatim but should clearly outline the definition of sexual abuse of a resident by another resident and sexual abuse of a resident by a staff.
5. Revise the PREA Policy 2.13 Section III titled Definitions, to include the definition for "Voyeurism by a staff member" as Voyeurism is a form of sexual abuse as defined under PREA Standard definitions 115.6.
6. Revise PREA Policy 2.13. Section III titled Definitions to clearly define sexual harassment as defined under PREA Standard definitions 115.6. It does not have to read verbatim but should clearly outline the definition of sexual harassment of a resident by another resident and sexual harassment of a resident by a staff.
7. Train staff on the revised PREA policy.
8. Document that staff have received training on the revised PREA policy.
9. Educate residents on the revised resident handbook.
10. Document residents have received updated education on the revised resident handbook.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services DYRS Contracts (updated 11/20/20). 2. Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, D pp 11, (revised 3/01/20). http://www.kids.delaware.gov/mss/mss_contracts.shtml 3. Pre-Audit Questionnaire (PAQ) 4. Community Specialist Corporation (New Outlook Academy). 5. Detroit Behavioral Institute, DBA Capstone Academy PREA Final Report 6. Diversified Treatment Alternatives PREA Final Report 7. George Junior Republic PREA Final Report 8. Keystone Continuum LLC DBA Natchez Trace Youth Academy PREA Final Report. 9. Summit School Inc. (Summit Academy) PREA Final Report 10. Vision Quest RAD PREA Final Report 11. White Deer Run (Cove Prep) PREA Final Report 12. Woodland Academy PREA Final Report 13. Community Specialist Corporation (New Outlook Academy) Contract. 14. Detroit Behavioral Institute, DBA Capstone Academy Contract 15. Diversified Treatment Alternatives Contract 16. Keystone Continuum LLC DBA Natchez Trace Youth Academy Contract 17. Vision Quest RAD Contract Interviews: 1. Agency Contract Administrator Findings (by Provision): 115.312 (a) 1-4: The agency reported in the Pre-Audit Questionnaire (PAQ) that they have entered into or renewed a contract for confinement of residents. The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, D page 11, establishes that providers shall comply with all applicable PREA standards and any DSCYF policies or standards related to PREA for preventing, detecting, monitoring, investigating and eradicating any form of sexual abuse within DSCYF contracted or subcontracted facilities. In review of the DYRS residential contracts dated (11/2020), the agency reported they had 15 contracts with facilities for confinement of residents and there was no contract that did not require contractors to adopt and comply with the PREA standards. The DYRS residential contracts list the facilities, contact information, website, PREA compliance manager, and status of compliance under the standard. The auditor reviewed five of the nine contracts for confinement of the agency's residents. The contracts reviewed has a section on reporting requirements that specifically require contractors to maintain compliance with the DSCYF operating guidelines. The DSCYF operating guidelines is located on the agency's website at http://www.kids.delaware.gov/mss/ mss_contracts.shtml and does require the contractor to comply with the PREA standards. The agency reported that six out of the 15 facilities had less than 51% Juvenile Justice. Since the last PREA audit, the agency had nine facilities that were under contract. In review of the contractor's website, all nine had a final PREA audit report listed on the contractor's website. The evidence shows that the agency has entered into contracts for confinement of residents and that those contracts require the providers to adopt and comply with the PREA standards as verified through the review of the PAQ, contracts, provider website and agency guidelines. 115.312 (b) 1-2: The Division of Youth Rehabilitative Services DYRS Operating Guidelines for Contracted Children and Family Programs and Services Section V, D page 11, establishes self-monitoring requirements and submission to PREA state or federal audits. Providers will allow DSCYF announced or unannounced compliance monitoring to include on-site monitoring. In the PAQ, the agency reported that six facilities are less than 51% juvenile justice and do not require the agency to monitor the contractor for compliance with PREA standards. In review of the DYRS residential contracts dated (2/2020), agency has a list of all contracts that includes the contract information for the provider, PREA compliance manager information, website and status of PREA final audit report. Six providers were listed as having less than 51% juvenile justice youth. During an

	interview with the agency contract administrator, only contracts with PREA eligible providers is monitored for compliance. Once a provider enters into contract, they are to comply with the PREA standards. Providers that are less than 51% juvenile justice do not require the agency to monitor the contract for compliance with PREA standards. The auditor randomly selected and reviewed six contracts that are less than 51% juvenile justice that confirms the agency's compliance with this provision. The evidence shows that the agency does require monitoring of a contractors' compliance with the PREA standards with the providers unless the provider is less than 51% juvenile justice. This was verified through review of the PAQ, agency guidelines, provider website and interview with agency contract administrator. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations: 1. Revise the contract reporting requirements section for PREA to state "contractor is required to adopt and comply with PREA standards".

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Stevenson House Detention Center Staffing Plan (1/1/2020). 3. B Shift January Schedule (1/2021) 4. Youth Rehabilitative Services Strategic Plan 2019-2022. 5. Director's Team Meeting Minutes (2/3/2020) 6. Director's Team Meeting Minutes (8/7/2020) 7. Administrator/Supervisor Visitation Log D Unit Interviews: 1. Superintendent 2. PREA compliance manager 3. PREA coordinator 4. Intermediate or higher-level facility staff Findings (by Provision): 115.313 (a-c): In the PAQ, the agency reported that they require each facility it operates to develop, document, and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and video monitoring, to protect residents against abuse. The facility reported that the average daily number of residents at the facility was 16 and the staffing plan was predicated on that number. At the time of the onsite audit, there were 31 residents at the facility. The facility reported in the last 12 months they have not deviated from the staffing plan as staff are frozen on shift as needed to ensure they remain in compliance with staffing ratios. Staff reported that they do maintain staff ratios at minimum 1:8 during resident waking hours and at minimum 1:16 during resident sleeping hours. The facility relies on PREA Policy 2.13 Section IV Titled Procedures B, 1, that provides that the administration and supervisors have a responsibility to maintain staff to student ratio. The facility staffing plan outlines a daily shift minimum of seven staff for each of the three shifts. The shifts are A shift (7:00am -3:00pm), B shift (3:00pm-11:00pm), and C shift (11:00pm-7:00pm). The facility reported they currently employ 74 staff, nine contractors and six volunteers that may have contact with residents. In review of the Stevenson House Detention Center organizational chart, administrative and security staff consist of one Director, one Superintendent, one Assistant Superintendent, one management analyst, two administrative specialist, one food service supervisor, five cooks, one chaplain, eight youth rehabilitative counselor supervisors, three youth rehabilitative counselor III, one volunteer service coordinator, one recreation specialist, 57 Youth Rehabilitation counselors, one custodian and one laundry staff that work on either A shift 0600-1400, B shift, 1400-2200 or C shift 2200-0600. A review of the facility staffing plan outlines that C shift is staffed by a minimum of seven staff per shift and conducts 15-minute checks on the youth during sleeping hours and documents these checks in the unit logbook. There is a daily shift minimum of one staff per eight residents during A and B shift. The staffing plan requires that staff know where the residents are at all times, residents never left unsupervised, staff must conduct periodic headcounts and movement must be noted in the unit logbook. The auditor was able to observe that the residents were never alone and traveled in a group escorted by staff when they went from the unit to the classroom or library. Staff utilized radios for communication between other staff. On the first day of the onsite audit, thirty-one male residents resided at the Stevenson House Detention Center. The auditor observed one staff with three residents in classroom D, one staff and two residents in classroom C which exceeded the facilities reported 1:8 ratio. In the PAQ, the facility reported they have a video monitoring system and had not added any new technology in the past 12 months. During the onsite review, on February 15, 2021, the total number of residents was thirty-one, on February 16, 2021 the total number of residents was twenty-eight on February 17, 2021 the total number of residents was thirty. The Stevenson House Detention Center has a facility capacity count of 55. There are 77 video monitoring cameras installed throughout the facility in the housing units, yard, classrooms, visitation, dining area, library, game room, gym, canteen room, Intake area, medical/mental health, three cottages, multipurpose building and on the exterior grounds. All the cameras can be monitored by supervisory staff. The auditor did not observe any cameras in the bathroom. All cameras are date and time stamped and

has a retention of 90 days.

During interviews, the superintendent stated that the facility has a documented staffing plan with adequate staffing levels and video monitoring. The superintendent reported that the staffing plan considers accepted detention and correctional practices, any findings of inadequacy, resident population, staff positions, blind spots, programming schedule, any applicable laws, and sexual abuse unsubstantiated and substantiated findings at the facility. The superintendent stated she checks for compliance of the staffing plan through shift briefing as each shift is responsible for completing one at the end of shift. The facility maintains staffing ratios 1:8 and 1:12.

The evidence shows that the facility provides adequate staffing levels and video monitoring to protect residents against abuse. This was verified through policy, interviews, video monitoring, staff and supervisor shift assignments.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.313 (d):

In the PAQ, the facility reported at least once every year the facility, in collaboration with the agency's PREA coordinator, reviews the staffing plan to see if adjustments are needed to the staffing plan, prevailing staffing patterns, monitoring technology, allocation of agency or facility resources to ensure compliance with the staffing plan.

The agency provided the Youth Rehabilitative Services Strategic plan 2019-2022, the Directors team meeting that outline the agency’s discussion for staffing plans for PREA standards once a year and video monitoring system concerns.

During interviews, the PREA coordinator stated that assessments or adjustments to the staffing plan is discussed through directors’ team meeting at least quarterly.

The evidence shows that the facility does meet with the PREA coordinator to discuss the staffing plan to ensure compliance which was verified by interviews and director’s meeting minutes.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.313 (e):

In the PAQ, the facility reported they require that intermediate level or higher level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The facility reported that unannounced rounds are documented and cover all shifts and staff are prohibited from alerting other staff conducting rounds.

The agency relies on PREA Policy 2.13 Section V, B,4 that outlines supervisors and program managers are to conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment, and shall be on all shifts and highlighted in the unit logbook. Any and all staff are prohibited from alerting any staff of these supervisory rounds.

A review of the logbook shows that PREA unannounced rounds are documented on an Administrator/ Supervisor Visitation log. A review of the video system shows that rounds are being completed. The superintendent and assistant superintendent does PREA unannounced rounds on all shift and log such rounds in a red PREA log sheets that are stored in a three-ring binder.

During Interview, higher-level staff stated that they would tell anybody they were coming into a unit and would go on C unit at least twice a month. Staff indicated they would document in the round red book.

The evidence shows that the higher-level staff conduct unannounced rounds and they are documented in the red log book which was verified through review of the log books, policy, and interviews.

Based upon this analysis, the facility is substantially compliant with this standard and corrective action is not required.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services State Managed Facilities Searches of Youth, Visitors and Facilities (Revised 2/28/19). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 (Revised 3/5/19). 3. Stevenson House Detention Center Clothed and Unclothed Searches SHDC 220 (Effective 3/21/19) 4. Policy 5.7 Division of Youth Rehabilitative Services State Managed Facilities Youth Supervision and Movement (Effective 6/1/15). 5. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 6. PREA Resource Center Guidance in Cross Gender and Transgender Pat Searches (2/2015) 7. Male Staff Announce Sign and Female Announce Sign Interviews: 1. Random staff 2. Resident 3. Findings (by Provision): 115.315 (a): In the PAQ, the agency reported that they do not conduct cross gender strip or cross gender visual body cavity searches of residents. In the past 12 months the facility reported they did not conduct cross gender strip or cross gender visual body cavity searches of residents. The facility relies on Search of Youth, visitors and facilities policy 5.14 Section III A, unclothed searches are conducted by a minimum of two line staff of the same gender without touching the youth. Policy LGBTQI 2.20 Section IV titled search procedure. G 3-4, outlines that LGBTQI shall be asked about their preference of being searched. If the youth does not express a preference the same gender staff shall conduct the search. Search of Youth, visitors and facilities policy 5.14 Section IV F, outlines that youth shall never be subjected to a body cavity search unless authorized by the medical authority, when directed this shall occur in the hospital by hospital staff. During the onsite audit, the auditor did not observe that staff conducted cross gender searches of residents or reviewed a log where cross gender searches was conducted. The evidence shows that the facility does not conduct cross gender strip searches or body cavity searches of residents which was verified by policy, and onsite observation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.315 (b-c): In the PAQ, the facility reported that they do not conduct cross gender pat searches of residents, absent exigent circumstances. The facility reported in the past 12 months they had no cross-gender pat searches and none that involve an exigent circumstance. Policy 2.20 LGBTQI outlines that cross-gender searches should not occur except in exigent circumstances. In an exigent circumstance, a written report must be completed, reviewed, and approved by the program manager immediately following and submitted to the deputy director, PREA coordinator and PREA compliance manager. The auditor was able to observe the intake areas and speak with staff regarding the intake process. Staff stated that each resident is searched when they come into the facility by the same gender staff. The auditors observed the intake area that had two restrooms and shower area one for boys and one for girls. Two staff of the same gender would be present during a search of the resident that is not visible by any other staff or residents. The evidence shows that the facility does not conduct cross gender pat searches of residents which was verified by policy, and onsite observation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.315 (d):

In the PAQ, the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks.

The facility relies on policy 5.7 Youth Supervision and Movement Section IV E, 1, that outlines staff shall not observe youth of the opposite sex when they are dressing and or undressing, bathing, or using toilet facilities. Agency policy PREA 2.13 requires staff of the opposite gender to announce their presence when entering a resident housing unit area where residents are likely to be showering, performing bodily functions, or changing clothing.

During interviews with 13 random staff, when asked do you or other staff announce your presence when entering a housing unit that houses residents of the opposite gender, all 12 staff stated yes and all 13 staff stated they would announce female on the floor or male on the floor. When staff was asked if residents are able to dress, shower and use the toilet without being viewed by staff of the opposite gender, all 13 staff stated yes.

During interviews with 18 residents, when asked do male or female staff announce their presence when they enter your housing area or any area where you shower, change clothes, or perform bodily functions, all 18 residents stated yes, staff say female on the floor and when asked are you or other residents ever naked in full view of a female or male staff when using the toilet, showering or changing clothes, all 18 residents stated no.

During the onsite review, the auditor observed the unit bathrooms, shower area and toilet facility. The auditor asked staff about the use of the shower, toilet and how residents change clothes, staff stated only one resident can shower at a time, residents must disrobe in the shower area, there is a chair in the shower provided for residents use so they can get dressed before they come out of the shower and the door. All the toilet stalls have doors for privacy. The intake area has a bathroom for girls and a bathroom for boys.

The evidence shows residents are able to shower, change clothes and perform bodily functions without being viewed by non-medical staff of the opposite gender and that staff announce their presence when entering a residents housing unit which was verified by policy, interviews and observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.315 (e):

In the PAQ, the facility reported they have a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. In the last 12 months, no such search occurred.

Agency policy 2.20 LGBTQI section IV G, 2, outlines that LGBTQI youth will not be physically searched in a manner that is humiliating or degrading or for the sole purpose of determining the youth’s physical anatomy. If a youth’s gender is unknown, it will be determined during conversations with the youth, by reviewing medical records, or as a part of a broader medical examination conducted in private by a medical practitioner.

During interviews with 13 random staff, when asked are you aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining the resident’s genital status, all 12 staff stated they were aware of the policy.

During the onsite review, the auditor reviewed 11 resident files and interviewed 18 residents and determined there were no transgender or intersex residents at the facility during the onsite audit.

The evidence shows that the facility prohibits staff from examining residents for sole purpose of determining a resident’s genital status which was verified by PAQ, policy, interviews, file review and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.315 (f):

In the PAQ, the facility reported that 100 percent of security staff have received training on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

Agency policy 2.20 LGBTQI section IV J, (1-2), outlines that all staff shall receive training on how to communicate effectively and professionally with youth including LGBTQI or gender nonconforming youth. The facility uses the PREA Resource Center Guidance in Cross Gender and Transgender Pat Searches to train staff on pat down searches of transgender and intersex residents.

	During interview with 13 random staff, when asked did you receive training on how to conduct a cross gender pat down search and searches of transgender or intersex residents in a professional and respectful manner, consistent with security needs, all 13 staff stated they have been trained, 11 out of 13 staff stated that they had the updated training a year ago, one out of 13 staff stated they had the training six months ago. In review of the PREA Academy training on searches of transgender residents, the training outlines residents would be asked upon intake if they feel safest being searched by a male or female staff member. Review of training records confirm that 21 out of 24 staff completed the PREA online refresher training. The evidence shows that facility staff have received training on how to conduct cross gender pat down searches which was verified through interviews, training documentation, training records, policy, and onsite observation. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. PREA Policy 2.13.IV.B.6 2. DSCYF Policy 118.II 3. PAQ 4. Roster of Youth receiving Special Education Services- Provided during interview with Education Department. 5. State of Delaware Executive Department Office of Management and Budget Contract No. GSS19602-LINGUIST Interpretation & Translation Services- Foreign Languages effective 4/1/2019-3/31/2021 p.9 6. Quick Glance Interpretation & Translation Services Interviews: 1. Director of DYRS 2. PREA compliance manager 3. Random youth 4. Random staff 5. Education administrator Site Review: 1. Housing Units 2. Library 3. Medical/Mental Health Suite Findings (by Provision): 115.316 (a)-1: The DSCYF has taken steps to ensure that youths with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment for youths that are disabled. In agency policy, there is specifics that ensure that disabled youths receive the same equal access to services and information pertaining to the prevention, detection, and response to sexual harassment and sexual abuse. PREA Policy 2.13.IV.B.6 states each facility is to ensure that youth with disabilities of any kind, are given the same information to prevent, detect and respond to sexual abuse and sexual harassment in a format supportive of their disability. In the PAQ, the facility provided the contract for interpretation and translation services from the State of Delaware Executive Department Office of Management and Budget Contract No. GSS19602-LINGUIST Interpretation & Translation Services- Foreign Languages. The contract is a mandatory use contract that requires every state department and agency within the Executive Branch and Judicial Branch of the state government shall procure all material, equipment, and nonprofessional services through the statewide contract administered by Government Support Services. To locate services needed, the document includes the Quick Glance Interpretation & Translation Services. The auditor contacted a vendor on the list to inquire about services. The auditor was informed there was availability of Sign Language Services. During the interviews with random staff, there were 2 staff that knew about the interpretation and language services available to the youth at the facility. During the interview with the education administrator, students that received special education services and youths that were limited English proficient were asked to be identified. There were nine youth identified as receiving special education services. The special education classifications were not indicative of youths that would necessitate assistance or support in understanding the existing PREA delivery of information. There were no youth that had any speech impairment, blindness, physical disabilities, or hard of hearing, but there were youth that were identified that were learning disabled or cognitively impaired. Interview with the Director of DYRS, PREA compliance manager, and education administrator revealed that there are procedures implemented to ensure that youth with disabilities and limited English proficiency was receiving information related to PREA. Mentioned was the access to the interpretation and translation services that included sign language, and youths with visual impairments could be provided PREA information in larger print. If comprehension or literacy were an issue, youth could be assisted by a member of the education department. During interviews with youth, the auditor

specifically asked identified youth if they receive help when needed. All youth identified affirmed that they receive help when needed. Based on this analysis, the agency substantially meets compliance for this provision.

115.316 (b)-1:
In DSCYF Policy 118.II, it is the policy of the Department that all LEP persons must have equal access to Department services, whether they are delivered by the Department or its contractors and shall be entitled to language assistance at no cost to themselves.

Based on information provided on the PAQ, there were no youth that were in need of translation and interpretation services within the last 12 months. At the time of the onsite audit, there were no youth identified on the roster that were limited English proficient. It should be noted that Spanish is the second largest spoken language in the state of Delaware. Further questioning by the auditors elicited no limited English proficient youth.

Meaningful access to all aspects of DSCYF's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to youth who are limited English proficient are met through the availability of the contract for interpretation and translation services. In the PAQ, the facility provided the contract for interpretation and translation services from the State of Delaware Executive Department Office of Management and Budget Contract No. GSS19602-LINGUIST Interpretation & Translation Services-Foreign Languages. The contract is a mandatory use contract that requires every state department and agency within the Executive Branch and Judicial Branch of the state government shall procure all material, equipment, and nonprofessional services through the statewide contract administered by Government Support Services. To locate services needed, the document includes the Quick Glance Interpretation & Translation Services.

DSCYF adherence to the State of Delaware Executive Department Office of Management and Budget Contract No. GSS19602-LINGUIST Interpretation & Translation could not be verified at Stevenson House Detention Center, because there was no documented use of services at the facility. The auditor could only confirm availability of the services on the contract by contacting vendors provided. Auditor selected vendors from the Quick Glance Interpretation & Translation Services List to verify services available. Upon further review of the contract, it was found that all vendors must provide certified/qualified and experienced language professionals with relevant knowledge in the required field of expertise. Based on contract requirements, the interpreters and translators are screened to ensure individuals providing services were effective, accurate, and impartial both receptively and expressively.

During the onsite review, the auditors located limited posters pertaining to PREA in either English or Spanish. There was no informational material such as pamphlets within the facility in either English or Spanish pertaining to the prevention, detection, and response to sexual harassment, sexual abuse, and retaliation for reporting. The PREA compliance manager explained due to the continuous disinfecting process many items were taken off the walls and were removed from desks. Based on this analysis, the agency substantially meets compliance for this provision.

115.316 (c)-1-3:
Review of DSCYF Policy 118.II does not explicitly prohibit the use of youth interpreters, youth readers, or other types of youth assistants except in limited circumstances. The policy does state that Department staff should utilize language assistance services in any situations where they are not able to communicate at a satisfactory level with an LEP person. Utilizing the interview protocols for random staff, it was found that five out of thirteen random staff was not aware that youth could not be utilized as translators or interpreters.

There were no limited English proficient youth to interview nor documentation in PAQ to determine if youth interpreters, youth readers, or other types of youth assistants were utilized except in limited circumstances in the past 12 months. According to random staff, there has not been any limited English proficient youth. There was no documentation located by the auditor that there was an extended delay in obtaining another interpreter that could have compromised the youth's safety, first-responder duties, or the investigation of the youth's allegations. Based on this analysis, the agency substantially meets compliance for this provision.

The evidence demonstrates that DSCYF has taken steps to ensure that youths with disabilities and limited English proficiency have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Additionally, there was no utilization of youth interpreters, youth readers, or other types of youth assistants. It was verified by the agency's policies, contracts, youth roster, interviews, and site reviews.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Add to PREA Policy 2.13.IV.B.6 limited English proficient.
2. Increase the number of PREA Informational Posters in English and Spanish in all areas of facility.
3. Provide easily accessible information related to prevention, detection, and reporting of sexual abuse and sexual

	harassment in both English and Spanish. 4. Provide easily accessible pamphlets of victim advocacy services. 5. Train staff on the availability of language and interpretation services and prohibiting the use of youth readers, interpreters, and translators.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13 Attachment F-DYRS Hiring and Promotion Decisions 2. DYRS Policy 2.13.III 3. DYRS Policy 2.2.IV.B.1 4. DSCYF Policy 313 5. DSCYF Policy 318.IV.E 6. Human Resource Applicant Statement 7. Delacare Regulations 2.0- 301 Background Checks for Child -Serving Entities 8. Letter of Affirmation of NCIC 5 year Checks of Employees of Residential Cottages 9. Volunteer and Contractor Roster 10. Delaware Criminal Justice Information System (DELJIS) 11. Employee Files Interviews: 1. Human Resources Site Review: 1. Employment Files Findings (by Provision): 115.317 (a)-1: DSCYF has three implemented policies and forms to address PREA Standard 115.321 prohibiting the hiring, promoting, or contracting of anyone who may have contact with residents who has engaged, attempted to engage, convicted of sexual abuse in prison, jail, lockup, community confinement facility, juvenile facility, other institutions, the community, which was facilitated by force or coercion, consent, or unable to consent or has been civilly or administratively adjudicated of the above actions. Human Resource Applicant Form which is completed by new-hires to attest that they have not been engaged in above behaviors. This form only addresses sexual abuse. DYRS Policy 2.13 Attachment F-PREA Acknowledgement Form is an affirmation completed by employees at promotion and annually with evaluation. This form specifically addresses sexual abuse and sexual harassment. DYRS Policy 2.2IV.B.1 cited Division employees must remain free from criminal activity or involvement in substantiated cases of abuse/neglect that may lead to harm of a youth. Policy does not address sexual abuse and sexual harassment specifically just abuse and neglect. In Delacare Regulations 2.0- 301 Background Checks for Child-Serving Entities stated that persons seeking employment who have regular direct access to children or provide services to a child or children at a child-serving entity must have a background check completed before employment or during a conditional period of employment. As far as the practice, prior to employment, all candidates must complete a Human Resource Applicant Statement. The statement specifically states that DSCYF shall not hire, promote or contract with anyone who may have contact with youth who have engaged in behaviors outlined in PREA Standard 115.317. Annually and prior to promotion, employees must complete the PREA Acknowledgement Form which affirms that in the past 12 months, the employee has not engaged in behaviors outlined in PREA Standard 115.317. The auditor did locate this form in facility employee folders. Based on this analysis, the agency substantially meets compliance for this provision. 115.317(b)-1: In order to comply with Policy 318.Definitions.E new hire candidates being promoted are required to complete the Human resource Form which is an affirmation as part of the pre-employment reference check process. The employee would affirm that they have or have not been investigated for or engaged in sexual abuse in confinement, community, and civilly or administratively adjudicated. In the case of new hires candidates that complete the Human Resource Applicant Statement, there is no designation listed inquiring about sexual harassment. There is a service letter that is sent to previous employers.

The service letter does not specifically speak to sexual harassment, but the questions that are asked should be sufficient to capture the occurrence of sexual harassment. The PREA Acknowledgement Form is for employees to affirm that in the last 12 months they have or have not been investigated for or engaged in sexual assault or sexual harassment in confinement, community and civilly or administratively adjudicated. There is a designation regarding sexual harassment. Further,human resources affirmed that the agency considers prior incidents of sexual harassment in determining to hire or promote anyone. Based on this analysis, the agency substantially meets compliance for this provision.

115.317(c)-1-2
DSCYF Policy 313.III cites Title 31, Chapter 3, Section 309 of the Delaware Code requires of SBI and FBI records a review of the Department's Child Protection Registry be conducted on employees of the Department hired after September 1, 1989 who have regular direct access or unsupervised direct access to children and/or adolescents under the age of 18.

During the interview with the Criminal History Unit it was confirmed that criminal background checks are completed on all newly hired employees and contractors who may have contact with residents.

In DSCYF Policy 3.18.IV.E specifically address the mandates required by PREA. The policy states that PREA requires pre-employment reference checks for covered employees to determine whether the candidate (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; and/or (3) Has been adjudicated in civil court or administratively adjudicated (substantiated) in employment related hearings. Within the past 12 months, there were 12 new candidates at the Resident Cottages that had criminal background checks and child registry completed.

The auditor inquired of the Human Resources and Criminal Background Unit during the hiring process of new employees and contractors if the child abuse registry is consulted. Both agreed that the child abuse registry is consulted.

Further in the policy is the General Guidance for Pre-Employment Checks. According to the policy the pre-employment checks must be considered in hiring decision making. Additionally, all information provided on the employment application, resume, reference and pre-employment check materials may be verified, including but not limited to, contacting current and former employers. It was documented in the PAQ there were 15 new employees that received both criminal background checks and child abuse registry consults within the last 12 months. Based on this analysis, the agency substantially meets compliance for this provision. ``

115.317(d)-1-2
According to the DYRS Policy 2.13.III.a Definition the residential cottages' contractors are considered staff. The DYRS Policy 3.18.IV.E requires that criminal background checks are to be completed and child abuse registries consulted prior to enlisting the services of any contractor who may have contact with residents.

Inquiry was made by the auditor regarding the criminal background checks for contractors that were provided on the volunteer and contractor roster for the Residential Cottages. The criminal background checks had not been completed for 1 contractor and 2 volunteers selected by the auditor. Based on this analysis, the agency does not meet compliance for this provision. The auditors were provided a list that 1 contractor and 2 volunteers did not obtain criminal background checks or child abuse registry consult. Based on this analysis, the agency does not meet compliance for this provision.

115.317(e)-1
Provided through the supplemental files of the AOS the PREA coordinator provided a Letter of Affirmation for the five-year employee background checks of the Stevenson House Detention Center. Additionally, the auditor requested from the facility the criminal background dates and child abuse registry consult. The facility was able to verify all staff dates, but there were 1 contractor and 2 volunteers without criminal background checks or child abuse registry consult. DYRS employs the use of the Delaware Criminal Justice Information System (DELJIS). This system flags the department if any employee, contractor, or volunteer receives a criminal charge while employed with the agency. Only criminal charges that occur in Delaware are subject to be flagged. Based on this analysis, the agency does not meet compliance for this provision.

115.317(f)-1
The auditor reviewed DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form which is used as a continuing affirmative duty to disclose the engagement of sexual abuse in a place of confinement, convicted of engaging; attempting to engage in sexual activity in the community; or civilly or administratively adjudicated of said behavior and investigated in sexual harassment. Another form that was provided in the PAQ was the Human Resource Applicant Statement for new hire candidates. The form inquired about the above listed behaviors except sexual harassment. In the introduction of the form, it states the agency shall not hire, promote or contract with anyone who may have contact with youth who participated in above behaviors listed.

It was confirmed by human resources that the Human Resource Applicant Statement is completed by the new hire candidates and contractors. It was also confirmed that DYRS Policy 2.13 – Attachment F-PREA Acknowledgement Form is completed by employees annually and upon promotion. During the employee file review, the auditors requested copies of the

signed forms. There were 52 PREA Acknowledgement Forms completed by existing staff. There were 17 new hirers that completed the Human Resource Applicant Form during the application process. There were 5 forms that were not available to the auditors. Based on this analysis, the agency substantially meets compliance for this provision.

115.317(g)-1
DYRS has established two policies wherein material omissions regarding misconduct or false information shall be grounds for termination. Within DSCYF Policy 318.V.C states any false, misleading, or substantive omission of information provided by an applicant during any phase or by any means may be cause for rejection of the application, rescinding an offer, repealing all or part of the hiring process, or dismissal if employed by the State. Based on information provided by the superintendent, the auditor discovered there was a candidate who was found to be ineligible for hire based on information obtained from criminal background checks.

Found in DYRS Policy 2.2 maintains that employees have the responsibility to immediately disclose to their supervisor any criminal investigations, arrests, indictments, or convictions of themselves or any investigation of child abuse or entry onto the Child Abuse Protection Registry subsequent to initial employment. Failure to immediately notify a supervisor of any of the above, including final disposition, could result in discipline up to and including termination. Based on the list provided by the superintendent, there were no staff terminated for the omission of information from the application process. Additionally, there were no staff identified in the PAQ. Based on this analysis, the agency substantially meets compliance for this provision.

115.317(h)-1

According to human resources, DYRS would provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee to an institutional employee with a service letter and a signed consent by a former employee. Based on this analysis, the agency substantially meets compliance for this provision.

The evidence has shown that the agency has established policies and procedures that prohibit the hiring or promotion of employees or contractors who may have contact with residents who have engaged in sexual abuse in confinement, institutional settings, community or civilly or administratively adjudicated for said behaviors. The facility through practice has established forms and service letters to obtain information if an individual has any incidents of sexual harassment. The agency completes criminal background checks and child abuse registry consult prior to hiring for employees. The agency does complete background checks every five years or less for employees. In the case of two volunteers and a contractor, there was no adherence to the two practices. New hire candidates are required to disclose prior misconduct. Imposed on employees is a continuing affirmative duty to disclose any misconduct including PREA Standard 115.316(a). Any omissions or false statements are grounds for termination. With a written consent from a former employee, the agency would provide information of a substantiated allegation of sexual harassment and sexual abuse.

Based on this analyst, the facility does not meet compliance at this time and corrective action is needed.

Corrective Action

1. Complete criminal background checks on employees including contractors and volunteers who have contact with youth.

Best Practice recommendations:

1. Service Letter to specifically inquire about sexual abuse and sexual harassment towards coworkers, patients, clients, residents or children.
2. Need to add sexual harassment to the Human Resource Applicant Statement in accordance with Standard 115.317(b).
3. Add sexual harassment as a prohibiting factor to hiring and promoting DSCYF 3.18.E in accordance with Standard 115.317(b).
4. Add into DYRS Policy 2.13 FBI criminal background checks to be completed every 5 years since DELJIS captures only crimes committed in Delaware, and the agency's employees are comprised of Pennsylvania, New Jersey, and Maryland residents.

Verification of corrective action since the audit-

In response to the corrective action, the facility provided documentation to the auditor through the supplemental files of the OAS. For corrective action #1, the agency provided evidence of criminal history being completed for a contracted vendor. Additionally, there was evidence of request for volunteers to complete the criminal background process. Finally, there was evidence of denial of entrance to volunteers who had not completed the criminal background process.

The following actions were taken by the facility for corrective action #1: The criminal history unit provided an email that the criminal background check was completed for a contractor, and an eligibility letter was generated. Also, emails documenting the request for volunteers to complete the onboarding process was included in the OAS. Additionally, there was an email from the PREA coordinator denying the entry for all volunteers that had not completed the onboarding process which

	included the criminal background check and the child registry. The following individuals were copied on the email the superintendent, assistant superintendent, volunteer coordinator, and the criminal history unit. Corrective Action #1 The intent of the corrective action was to ensure that no individuals that did not complete the criminal background check and the child registry would have access to youth. Based on the review of the information received to date, the auditor finds that the facility substantially meets compliance with this standard.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Affirmation for PREA Standard 115.318 Interviews: 1. Director of DYRS 12/15/2021 2. Superintendent Site Review: 1. Central Control Findings (by Provision): 115.318 (a)-1: This provision is not applicable. According to the written affirmation provided by the superintendent, the agency nor facility has acquired a new facility or made substantial expansion or modification to existing facility. During the interview with the Director of DYRS, it was stated that sexual safety and physical safety are considered when designing, acquiring, and planning modifications to facilities. Additionally, it was stated that there were no new facilities or substantial modifications to the Stevenson House Detention Center. Uploaded to the supplemental file of the OAS, the superintendent of the facility attested there were no substantial modifications to the existing building. The facility is substantially compliant with this provision. 115.318 (b)-1: This provision is not applicable. Since the last PREA audit there was no additional installation or updated video monitoring system. Further research with the PREA compliance manager revealed that video monitoring system had the ability to capture footage up to 30 days. This improvement provides information to assist in the ability to protect and detect sexual abuse. There is more of an opportunity to review patterns of behaviors and actions. The Director of DYRS stated that there was no new monitoring technology at the Stevenson House Detention Center. During the site review, the auditors were informed that the camera system's DVR storage capacity was increased since the last PREA audit. During the prior audit, camera footage was only available up to 18 days. Though not a substantial enhancement, the camera system has the capability to capture footage up to approximately 90 days. The capability was further corroborated during interview with the superintendent. The facility is substantially compliant with this provision. The evidence provided in the supplemental files of the PAQ, substantiates that Stevenson House Detention Center has not acquired a new facility or made substantial expansion or modification to existing facility since the last PREA audit. The Stevenson House Detention Center has not installed any new video monitoring system or electronic surveillance system since the last PREA audit. This standard is not applicable to the Stevenson House Detention Center. Based on this analysis, the facility is substantially compliant with this standard and there is no corrective action required. Best Practice Recommendations: 1. Improve internal camera capabilities specifically blind spots in the classrooms and the rear sallyport next to intake.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.D.1-2 2. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect pp 79-101 3. US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents" 4. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults-Bayhealth Hospital, Sussex Campus formerly the Milford Hospital 5. Affirmation of Compliance with Investigative Standards for Sexual Assaults with Milford Police Department Interviews: 1. Institutional Abuse (IA) 2. Survivors of Abuse Recovery, Inc. (SOAR) 3. Milford Police (MPD) Findings (by Provision): 115.321 (a):-1-4 DYRS Policy 2.13.IV.D.1.h, specifically states incidents alleging sexual harassment that are not accepted by the Institutional Abuse (IA) Unit for investigation, shall receive an internal administrative review in an efficient time frame. The Stevenson House Detention Center does not conduct criminal investigations. Criminal investigations are conducted jointly with the Milford Police Department and IA. When conducting sexual abuse investigations, there is an existing memorandum of understanding which was contained in the PAQ. It is titled the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect. Within the document there is the Child Sexual Abuse Protocol. Found in the protocol there is a description and mention of PREA mandates. All police departments within the state of Delaware have signed this document. According to the IA investigator, there has been no sexual abuse allegation reported that occurred at the Stevenson House Detention Center within the last 12 months that would have necessitated the need to utilize the protocols. It was further confirmed in the PAQ. During the interview with MPD, it was disclosed to the auditors that there were 2 sexual abuse allegations reported at the facility. These allegations occurred in a state contracted facility and in the community. Based on this analysis, the agency substantially meets compliance for this provision. 115.321(b) State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect was developed for children. During the auditor's review, the protocols appear to be developmentally appropriate for youth. The document does not specifically cite as the framework the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." Upon further investigation with the PREA coordinator, it was found that the framework from the US Department of Justice's Office was not utilized. Rather the protocol was developed based on best practice. The auditor continues to make a comparison of both documents, it was found that there were commonalities between the protocols. Items covered in the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents: • Coordinated Team Approach • Informed Consent • Confidentiality • Reporting to Law Enforcement • Payment for the Examination Under VAWA • Sexual Assault Forensic Examiners • Facilities • Equipment and Supplies • Sexual Assault Evidence Collection • Timing Considerations for Collecting Evidence • Evidence Integrity • Initial Contact

- Triage and Intake
- Documentation by Health Care Personnel
- Medical Forensic History
- Photography
- Exam and Evidence Collection Procedures
- Alcohol and Drug-Facilitated Sexual Assault
- STI Evaluation and Care
- Pregnancy Risk Evaluation and Care
- Discharge and Follow-up
- Examiner Court Appearances

Majority of these key points were utilized in the creation of the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect. In the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Bayhealth Hospital, Sussex Campus SANE coordinator, the director of DYRS, Senior Vice President/CNE Bayhealth and the PREA coordinator, there is language in the document stating that the protocols employed at Bayhealth Hospital, Sussex Campus are appropriate for youth and adapted by the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." Based on this analysis, the agency substantially meets compliance for this provision.

115.321(c)-1-10
In DYRS 2.13.IV.D.2.a-b, it is referenced that all medical personnel gathering physical evidence or engaged in legitimate medical treatment while investigating prison rape will do so in a hospital setting. Existing is the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults between the Bayhealth Hospital SANE coordinator, the director of DYRS, Senior Vice President/CNE Bayhealth and the PREA coordinator. The affirmation states that forensic examinations are made available without consideration of cost to the youth where evidentiary or medically appropriate. Prior to the onsite audit of Stevenson House Detention Center, the auditors visited and interviewed the SANE Coordinator at the Bayhealth Hospital, Sussex Campus. According to the SANE Coordinator, there were no forensic examinations as a result of sexual abuse at the facility within the last 12 months. According to all three individuals interviewed from the affirmation, there were no incidences that required forensic examinations within the last 12 months. Further in the DYRS Policy, all medical interventions for PREA related incidents in Kent and Sussex County will be referred to Milford Hospital which has been renamed to Bayhealth Hospital, Sussex Campus. The affirmation detailed that forensic medical examinations would be completed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) or other qualified medical practitioners. According to PREA coordinator, IA, and documentation provided in the PAQ, there were no forensic medical examinations sent to Bayhealth Hospital, Sussex Campus within the last 12 months. Based on this analysis, the agency substantially meets compliance for this provision.

115.321(d)-1-3
Through a memorandum of agreement, Survivors of Abuse Recovery, Inc. (SOAR) and YRS have an agreement for SOAR to provide victim support services to individuals who have been a victim of sexual abuse. The services include support during forensic medical examination and emotional support during the investigative process, and counseling while in custody.

DYRS Policy 2.13IV.E.1.a-b, referenced that counseling services will be made available to all youth involved in non-consensual sex, abusive sexual contact, or sexual harassment through: the designated hospitals for evaluation and treatment and the Division of Prevention and Behavioral Health (now DYRS staff) psychologist or DYRS contracted provider while the youth remains in custody or as a follow-up for facility release/discharge. During the random resident interviews, there were no residents who reported sexual abuse. Based on this analysis, the agency substantially meets compliance for this provision.

115.321(e)-1
Through a memorandum of agreement, Survivors of Abuse Recovery, Inc. (SOAR) and YRS have an agreement for SOAR to provide victim support services to individuals who have been a victim of sexual abuse. The services include support during forensic medical examination and emotional support during the investigative process, and counseling while in custody. In the affirmation between DYRS and Bayhealth Hospital, Sussex Campus, there is reference that the hospital would make available to the victim, a victim advocate, qualified agency staff member, or a qualified community-based organization member with support through the forensic medical examination process, investigatory interviews, and assist in providing emotional support, crisis intervention, information, and referrals. The auditors interviewed SOAR, and it was confirmed by the staff of SOAR that the agency had an affirmation with DYRS. During an interview with SOAR on 2/23/2021, it was confirmed that the services listed in the affirmation were still available to victims at Stevenson House Detention Center. Based on this analysis, the agency substantially meets compliance for this provision.

115.321(f)-1
Criminal investigations at the Stevenson House Detention Center are conducted by the Milford Police Department. DYRS and the MPD has implemented the Affirmation of Compliance with Investigative Standards for Sexual Assaults. The

affirmation contains the requirements mandated by PREA Standard 115.321(a)-(e). Based on this analysis, the agency substantially meets compliance for this provision.

The evidence shows that DYRS is responsible for conducting administrative sexual abuse investigations in cases that IA screens out the allegations. When it is determined that the allegations meet the criminal threshold by IA, criminal sexual abuse allegations are conducted by the MPD in conjunction with IA. The State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect, the Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults, and the Affirmation of Compliance with Investigative Standards for Sexual Assaults are developmentally appropriate protocols for youth. The three protocols are an adaption of the US Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examination, Adult/Adolescents." DYRS provides forensic medical examinations utilizing the SANE/SAFE from Bayhealth Hospital, Sussex Campus. Residents are provided victim advocacy services from SOAR, a community-based victim advocacy agency.

Based on this analysis, the agency substantially meets compliance for this standard.

Best Practice Recommendations:

1. Revise DYRS Policy 2.13.IV.D.1.h from administrative review to administrative investigation
2. Revise DYRS Policy 2.13.IV.D.1.b. to include sexual abuse instead of prison rape.
3. Revise DYRS Policy 2.13IV.D.2. b. to reflect the name change of Milford Hospital to Bayhealth Hospital, Sussex Campus

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, D (b-h), pp 6-7, (Revised 6/29/17). 2. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Sexual Violence Incident Form Attachment A. 3. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Sexual Violence Incident Form Attachment B. 4. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Sexual Violence Incident Form Attachment C. 5. Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Sexual Violence Incident Form Attachment D. 6. Policy 2.12 Division of Youth Rehabilitative Services Professional Practices Reportable Events Section III A-5, B-1 page 1, (Revised 6/27/14). 7. Policy 2.12 Division of Youth Rehabilitative Services Professional Practices Reportable Events Critical Reportable Event Attachment A, (Revised 5/14). 8. Policy 2.12 Division of Youth Rehabilitative Services Professional Practices Reportable Events Non-Critical Reportable Event Attachment B, (Revised 5/14). 9. Policy 208 Institutional Abuse Section V, page 2, (revised 6/8/16). 10. Child Sexual Abuse Protocol Memorandum of Understanding (Final 2017), (pp. 5) Interviews: 1. Agency head 2. Investigative staff Findings (by Provision): 115.322 (a) 1-5: In the PAQ, the agency reported they ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Although a policy is not required for this provision, the agency relies on Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV, D, page 6-7, that states all matters that involve the allegation of any sexual contact as defined in this policy will be reported to the child abuse hotline. The policy further outlines that for matters which could result in a criminal action, institutional abuse will conduct a joint investigation with the Delaware State Police or Milford Police. Staff sexual misconduct will be reported to the Child Abuse Hotline to address all matters involving staff actions that may not be of a criminal nature, yet still violates PREA, such as conversations or correspondence of a romantic or sexual nature. Incidents alleging sexual harassment that are not accepted by the Institutional Abuse Unit for investigation shall receive an internal administrative review in an efficient time frame. As written, the policy does not ensure that an administrative investigation is completed for all allegations of sexual harassment. The YRS Policy 2.13 attachment A, sexual violence incident form establishes when an incident of sexual violence is identified on a reportable event form the sexual violence form is to be completed and included with the reportable event form. The sexual violence incident form defines types of sexual violence as non-consensual sexual act, abusive sexual contact and sexual harassment. In the PAQ, the agency reported, Policy 2.12 Division of Youth Rehabilitative Services Professional Practices Reportable Events Section III A-5, B-1 page 1, defines a critical reportable event as one that involves institutional abuse or child abuse resulting in arrest of an employee or provider in a department operated or contracted program for the maltreatment of a child with the department and a non-critical reportable event that involves the allegation of institutional abuse. The policy outlines a reportable event as institutional abuse, child abuse and allegation of institutional abuse but does not specifically outline sexual abuse and sexual harassment as a reportable event. The types of reportable events are categorized as critical and non-critical which provides a specific type of reporting requirement based on the severity of the incident. In review of the critical and non-critical reportable event form, institutional abuse is listed on both forms and child abuse is listed on the critical reportable event form. Neither the critical reportable event form nor the non-critical reportable event form defines sexual abuse and sexual harassment as a reportable event that would prompt an immediate telephone, voicemail or email notification. A review of Policy 208 Institutional Abuse Section V, page 2, outlines that the Institutional Abuse Investigation Unit will screen reports of alleged sexual abuse by a DSCYF employee, investigate utilizing DFS Institutional Abuse Investigation

Protocol policy and procedures, formulate findings and cite concerns obtained during the investigation and distribute findings and cite concerns to be distributed to the appropriate division or external entity.

The facility reported in the PAQ there were no sexual abuse and sexual harassment allegations reported in the past 12 months that resulted in an administrative investigation and no allegations referred for criminal investigation in the past 12 months. The facility PAQ indicated that there were no allegations received during the last 12 months for an administrative investigation.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

During an interview, the Agency stated that they ensure that administrative and criminal investigations are completed. Allegations of sexual abuse goes through internal affairs protocol reviewing the case and referring to Law enforcement. Internal Affairs would handle the criminal investigations and the facility would handle the administrative investigation. During interviews with Internal affairs investigator and Milford Police Department, the auditor was able to determine that there was no criminal cases of sexual abuse or sexual harassment received during the audit period for the Stevenson House Detention Center.

Internal Affairs investigates administrative allegations and criminal allegations are investigated by Milford Police Department. The superintendent is the point of contact and the contract unit would be contacted for only reportable events from contracted agencies.

The evidence shows that there was no allegations of sexual abuse or sexual harassment reported in the last 12 months preceding the onsite audit. The agency reported that they did not have any allegations in the 12 months preceding the onsite audit. This information was verified through interviews, policy, and the PAQ.

Based upon this analysis, the auditor finds the facility is not substantially compliant with this provision and corrective action is required.

115.322 (b) 1-3:

In the PAQ, the agency reported that they have a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior.

Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV, D, page 6-7, outlines that all matters that involve the allegation of any sexual contact as defined in the policy will be reported to the child abuse hotline. The policy requires that matters which could result in a criminal action, institutional abuse will conduct a joint investigation with the Delaware State Police or Milford Police. All matters that may not be of a criminal nature will be reported to the Child Abuse Hotline and acts deemed to be a criminal offense as recognized by the child abuse hotline, will be referred to the Delaware State Police or Milford Police. Incidents alleging sexual harassment that are not accepted by the Institutional Abuse Unit for investigation shall receive an internal administrative review in an efficient time frame. As written, the policy does not require that allegations of sexual harassment are referred for investigation.

In the PAQ, the facility outlined in the Child Sexual Abuse protocol (MOU), page 5, a civil offense of sexual abuse as any sexual contact, sexual intercourse, or sexual penetration as defined in the Delaware Criminal Code between any individual and a child. This protocol outlines that DFS must make an immediate report to the appropriate law enforcement jurisdiction for all civil offenses identified in the sexual abuse protocol and document its contact with the appropriate law enforcement agency.

In the PAQ, the agency reported the policy regarding referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency's website or made publicly available via other means. The agency provides that Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act PREA (https://kids.delaware.gov/yrs/prea-statutes-policy.shtml) is publicly available. The auditor reviewed the agency's website and determined that Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) is available on the website but does not include the referral of allegations of sexual abuse or sexual harassment for a criminal investigation.

The agency relies on Policy 2.12 Reportable events as evidence that all referrals of allegations of sexual abuse or sexual harassment for criminal investigation is documented. As written, the policy does not outline sexual abuse and sexual harassment as a reportable event.

The auditor was able to determine that there was no criminal cases of sexual abuse or sexual harassment received during the audit period for the Stevenson House Detention Center.

During an interview, facility investigator stated that all allegations of sexual abuse and sexual harassment are referred to the Milford Police Department. The auditor was able to interview an investigator with the Milford Police Department who was responsible for conducting criminal investigations for allegations of sexual abuse and sexual harassment and they would send the rape kit to Milford police. Milford Police Department reported they have not had any sexual abuse or sexual harassment cases in the last 12 months that occurred at the facility. The Milford Police staff stated if they receive a call, they respond immediately. Milford staff described that their process involved conducting interviews and gathering evidence.

The evidence shows that the agency has a policy that outlines the investigation process but does not specifically require that allegations of sexual harassment be referred for investigation, unless the allegation does not involve potentially criminal behavior. The agency Child Sexual Abuse protocol (MOU), does establish a reporting requirement to the appropriate law enforcement for all criminal offenses and documenting that contact. The MOU was not located on the agency's website.

Based upon this analysis, the auditor finds the facility is not substantially compliant with this provision and corrective action is required.

115.322 (c):

Under this provision the standard requires that if a separate entity is responsible for conducting criminal investigations, does the publication describe the responsibilities of both the agency and the investigating agency. The agency has a policy that is published on the agency's website that identifies the agency and Milford Police for conducting joint criminal investigations. As written, the policy does not describe the responsibilities of the agency or Milford Police.

Based upon this analysis, the auditor finds the facility is not substantially compliant with this provision and corrective action is required.

Based upon this analysis, the auditor finds the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Revise Policy 2.13 PREA Section IV, D, to require that all allegations of sexual harassment be referred for investigation.
2. Publish the revised policy on the agency's website that require that all allegations of sexual harassment be referred for investigation.
3. Document all referrals.
4. Revise Policy 2.13 PREA Section IV, D to describe the responsibilities of both the agency and Milford Police Department for conducting sexual abuse or sexual harassment criminal investigations. Publish on the agency public website.
5. Train staff on the revised policies.
6. Document that staff have received training on the revised policies.

Best Practice Recommendations:

1. Revise YRS Policy 2.13 Sexual Violence incident form attachment A, B, C, D to include sexual abuse and sexual harassment as defined in PREA Standard 115.6.
2. Revise Policy 2.12 Reportable Events Section III A-5, B-1 to include sexual abuse and sexual harassment as defined in PREA Standard 115.6.
3. Revise YRS Policy 2.12 Reportable Events Critical reportable event form Attachment A and non-critical reportable event form Attachment B to include sexual abuse and sexual harassment as defined in PREA Standard 115.6.
4. Train staff on the revised policies.
5. Document that staff have received training on the revised policies.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 6/23/21, 7/15/21, 7/16/21 in response to the corrective action recommendations.

1. Provided revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21). (11 pages).
2. Provided publication of the revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21) on the agency's website http://kids.delaware.gov/policies/yrs/2.13_PREA_PrisonRapeEliminationAct.pdf
3. Revised PREA Policy 2.13 Staff Training Roster (8 pages).
4. Revised PREA Policy 2.13 Staff Training Roster (2 pages.

The following action were taken: DYRS revised their PREA policy 2.13 on 5/13/21 to reflect that all allegations of sexual

abuse and sexual harassment are reported to the child abuse hotline and screened for institutional abuse investigation. Institutional abuse may complete a joint investigation with Milford Police for all allegations that involve potentially criminal behavior. Any allegation that Institutional abuse does not investigate will be administratively investigated by facility PREA investigators. As a best practice, the agency revised the PREA policy 2.13 to include sexual abuse and sexual harassment as defined in PREA standard 115.6.

Corrective Action #1, #4, #5

The intent of this corrective action was to ensure that administrative or criminal investigations were referred and completed for all allegations of sexual abuse and sexual harassment. The agency provided a revised PREA policy to the auditor. The agency took action and revised their policy to outline sexual abuse and sexual harassment reporting for investigation. The revised policy requires that all allegations of sexual abuse and sexual harassment be reported to the sexual abuse hotline and screened for institutional abuse investigation. The policy provides that the agency Institutional Abuse may conduct a joint investigation with the Milford police for allegations that potentially involve criminal behavior. Any allegation not investigated by Institutional Abuse will be administratively investigated by the facility PREA investigators. The facility provided 10-page training roster that included 65 staff signatures acknowledging that they were trained on the agency's revised PREA policy 2.13. This satisfies the auditor's corrective action requirement.

Corrective Action #2

The intent of this corrective action was to ensure that the agency policy that outlined the referral process for sexual abuse and sexual harassment for criminal investigations was available on the agency's website. The agency provided the auditor with the revised PREA policy and notification that it was posted on the agency's website. A review of the agency website at http://kids.delaware.gov/policies/yrs/2.13_PREA_PrisonRapeEliminationA
ct.pdf provides that the revised PREA policy is publicly available on the agency's website. This satisfies the auditor's corrective action requirement.

Corrective Action #3

The intent of this corrective action was to ensure that the agency documents all referrals for sexual abuse and sexual harassment. The facility reported one allegation during the corrective action period. The facility provided a 10-page reported that confirms that the agency documents all referrals for sexual abuse and sexual harassment. This satisfies the auditor's corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.A 2. DSCYF Academy Staff Training PowerPoint 3. PREA Refresher Training Roster 4. Staff Roster 5. PAQ Interviews: 1. Random Staff 2. PREA Coordinator 3. Training Administrator Findings (by Provision): 115.331 (a)-1-11: All new hires are provided PREA training during their orientation at the Center for Professional Development. All employees are to complete refresher training every 2 years. Though not required, DYRS has implemented Policy 2.13.IV.A.1.a-c to address PREA training for all employees. In the policy, employees include agency employees, contractors, and volunteers. The policy states that all department staff working with or monitoring programs/services of youth in secure care and community services must receive PREA training. Further, the policy details that the Center for Professional Development will provide the training to all new DYRS employees during orientation. DYRS staff are to re-new this training every two years. In the case of contractors and volunteers, PREA training is completed by the volunteer and contractor coordinator. Lastly, the training will include, but not be limited to, complaint recipient responsibility, how to report an incident, coordinated responses duties, investigations, and how to access victim services. The auditors were provided the training material in the PAQ. The initial PREA training is provided in person, and instructions are led utilizing a PowerPoint presentation which is based on the Moss Group training materials for PREA. Located in the Academy Staff Training on slide 4, there is specific language that addresses the agency's Zero-Tolerance Policy. The slide was titled Zero-Tolerance Policy. Underneath, the slide read DYRS commits to full compliance with the Prison Rape Elimination Act (PREA). There are two statements that are bulleted. The first bullet states DYRS has a zero-tolerance for any incidence of sexual abuse of youth in our care, and the last bullet details any type of forced or unwanted sexual activity, touching or sexual harassment between youth or any type of sexual activity or sexual harassment between staff and youth is criminal and prohibited.

DSCYF Academy Staff Training PowerPoint Presentation	
Subject Matter	Slide Number
Agency's zero-tolerance policy for sexual abuse and sexual harassment	Slides 3-6
Responsibilites of prevention, detection, reporting, and response policies and procedures	Slides 36-55
Right of residents to be free from retaliation for reporting sexual abuse and sexual harassment	Slide 6
Rigth of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment	Slide 46
Dynamics of sexual abuse and sexual harassment	Slides 26-35
Common reactions of juvenile victims of sexual abuse and sexual harassment	Slides 33-35
How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents	Slides 8-17
How to avoid inappropriate relationships with residents	Slides 70-83
How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents	Slides 56-59
How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities	Slides 42-44
Relevant laws regarding the applicable age of consent	Slides 8-11

Utilizing the PREA protocols for random staff, the auditors found that all 13 random staff interviewed stated that they had received PREA training at orientation and PREA refresher training.

Comparison of the medical staff certificates to the PREA Refresher roster indicated that none of the medical staff had completed the PREA Refresher. Also, there is no evidence that the medical staff received initial comprehensive PREA training. The facility does meet compliance in this provision.

115.331(b)-1-2

During interviews with the PREA coordinator and the training administrator, it was found there was no separate training for female and male facilities. Staff is provided comprehensive training to work with both males and females. The facility substantially meets this provision.

115.331(c)1-2

In accordance with DYRS Policy 2.13.IV.A.1.b., employees are required to participate in PREA refresher trainings. During the interview with the training administrator, it was found that the refresher training is provided online. Based on information obtained from the randomly interviewed staff, they received PREA refresher trainings. Based on the PAQ, the PREA refresher training is completed annually.

Comparison of staff rosters and the PREA training refresher roster, the auditor was able to determine that 41 of 74 staff members had received the PREA refresher training. It should be mentioned that 17 individuals were hired within 12 months and received PREA training through the Center of Professional Development. Review of the staff roster and the PREA refresher training roster, there were 41 out of 74 staff had completed the PREA refresher training. During the onsite audit, there were only eight new hirers that were still employed at the facility. Out of the eight only one was duplicated on the staff roster and the PREA refresher roster. Additionally, there were two administrators found on the list who were not included in the staff count of 74. There were 33 staff members that did not take the PREA refresher which computes to 45% of the staff at the facility had not received the PREA refresher training.

There were no medical staff provided PREA refresher training. In years in which there was not a refresher training, there was no evidence in staff files of refresher information distributed on current sexual abuse and sexual harassment policies. The facility does not meet compliance in this provision.

115.331(d)-1

The auditor received a roster of completion of the PREA refresher training, but this information may not have been an electronic verification that the employees understood the PREA training, but rather a verification that the individual participated in the training. According to the training director employees are provided a prompt that confirms that there is understanding of training. The facility substantially meets compliance in this provision.

The evidence has proven that all staff receive a comprehensive PREA training during orientation. The training meets all PREA standard requirements of 115.331(a). Stevenson House Detention Center has provided PREA Refresher training to 55% of the staff. The facility does not substantially or consistently provide the necessary PREA Refreshers. Additionally, there was no evidence that the medical staff received comprehensive PREA training or PREA refresher training. The number of medical and mental health staff that did not complete PREA refresher will be addressed in PREA Standard 115.335. According to the training director, acknowledgements of understanding are maintained in the training database.

Based upon this analysis, the facility does not meet compliance with this standard and corrective action is required.

Corrective Action

1. All staff need to complete PREA Refresher training every 2 years. In years that there is no refresher training, there needs to be evidence of the agency providing refresher information on current sexual abuse and sexual harassment policies.

Best Practice Recommendations:

1. Include Zero-Tolerance for sexual abuse and sexual harassment and how to report an incident of sexual abuse and sexual harassment in DYRS Policy 2.13.IV.A.1.c.
2. Include on slide 4 of DSCYF Academy Staff Training that DYRS has a zero-tolerance for any incidence of sexual abuse and sexual harassment of youth in our care. Any type of sexual abuse or sexual harassment between youth or any type of sexual abuse or sexual harassment between staff and youth is criminal and prohibited.
3. Maintain a copy of individualized transcripts from Learning Management System in employee file.
4. In DSCYF Academy Staff Training PowerPoint presentation expound on the laws related to the age of consent.
5. Provide documentation in employee file by either employee signature or electronic verification that employees understand the PREA training received in accordance with 115.311(d).

Verification of corrective action since the audit-

In response to the corrective action, the facility provided documentation to the auditor through the supplemental files of the OAS. For corrective action #1, the facility provided the employee PREA Refresher training roster dated 7/16/2021.

The following actions were taken by the facility for corrective action #1: The facility provided PREA refresher training as well as training on the revised PREA Policy 2.13. The roster provided evidence that there were 87 out of 88 employees that were

	registered and completed the PREA Refresher training. Corrective Action #1 The intent of the corrective action was to ensure that all staff were provided PREA Refresher training every 2 years, Based on the evidence provided to date, Stevenson House Detention Center is substantially compliant with the standard.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13.III 2. DYRS 2.13.IV.A.1 3. Stevenson House Detention Center Security Orientation Packet 4. Volunteer Files Interviews: 1. Volunteers 2. Contractors 3. Volunteer and Contractor Coordinator Findings (by Provision): 115.332 (a):-1-2 According to DYRS 2.13.III, staff is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative. Further in DYRS 2.13IV.A.1, all department staff working directly with or monitoring programs/services of youth in secure care and community services must receive PREA training. Volunteers and contractors are to be trained on the agency's zero-tolerance policy for sexual abuse and sexual harassment. It should be noted that the volunteer and contractor coordinator started their position at the onset of the Covid pandemic. The files were limited and inherited from prior volunteer and contractor coordinator. The volunteer and contractor coordinator provided the auditors with the Stevenson House Detention Center Security Orientation packet. This packet is utilized to train volunteers and contractors who have contact with youth. Within the packet there is a checklist which is initialed by volunteers and contractors once completed. The auditors noticed that the policy indicated for PREA was incorrect, and there was no information pertaining to PREA, and there was no information regarding the agency's zero-tolerance policy for sexual abuse or sexual harassment within the packet. The packet addressed sexual abuse but not sexual harassment. The specifics of prevention, detection, and reporting were intertwined in the child abuse section of the packet. There were no specifics which related to PREA. In the PAQ, it was indicated that there were 12 volunteers and contractors. During the onsite audit, the auditors were provided a roster for both volunteers and contractors. There were 9 contractors and there were 6 volunteers. There was a total of 4 volunteer folders available for the auditors to review. All 4 folders contained evidence of the completion of the checklist that acknowledges they received orientation. Based on the information provided in the packets, the volunteers did not receive training specific to PREA. From the list provided by the volunteer and contract coordinator, the auditor interviewed two volunteers and three contractors. All the of the volunteers recalled some form of training pertaining to PREA during the orientation at the Stevenson House Detention Center. One of the three contractors stated there was no training pertaining to PREA or the agency's zero-tolerance. The auditor further attempted to assess compliance by interviewing the volunteer and contract coordinator. The auditor determined information was limited due to the volunteer and contract coordinator having recently being placed in the position. Majority of the information was inherited and was completed prior to Covid Pandemic. As of March, onsite programs for residents were discontinued at the Stevenson House Detention Center. It should be mentioned that the volunteer and contract coordinator is responsible for contracts that provide activities for residents not the medical or mental health practitioners' contract. The agency does not meet compliance in this provision. 115.332(b)-1-2 The auditor determined that volunteers and contractors are provided orientation to the facility. The volunteer and contract coordinator provided the Stevenson House Detention Center Security Orientation Packet. Upon completion, the checklist is initialed by the participants. In the packet, the auditor determined that volunteers and contractors are not trained in the agency's zero-tolerance policy regarding sexual abuse and sexual harassment or the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. There was no evidence of this information provided in the orientation

packet. The agency does not meet compliance in this provision.

115.332 (c)-1

Based on the review of the 4 volunteer files, the auditor concluded that the volunteer and contractor coordinator does not maintain all the folders of volunteers and contractor's orientation documentation. Additionally, there was no evidence provided in the PAQ of maintenance of this information. The agency does not meet compliance in this provision.

Based on this analysis, the facility does not meet compliance with this standard and corrective action is required.

Corrective Action

1. Volunteers and contractors who have contact with youth shall be notified of the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Orientation material should be reflective of the training provided, and documentation of this training should be documented in all volunteers and contractors' files.
2. Maintain all documentation pertaining to PREA training for volunteers and contractors who have contact with youth.

Verification of corrective action since the audit-

In response to the corrective action, the facility provided documentation to the auditor through the supplemental files of the OAS. For corrective action #1, the facility provided updated onboarding documentation for volunteers and contractors. There was evidence of a completed acknowledge form signed electronically on 5/7/21 by a prior volunteer/contractor. Due to Covid 19, there have been no new contractors or volunteers providing services due to Covid 19 pandemic, the auditor was unable to determine improvement in the practice of maintaining onboarding files for new contractors or volunteers.

The following actions were taken by the facility for corrective action #1: The facility revised their existing volunteer/ contractor packet to include the revised PREA Policy 2.13 with the addition of a PREA acknowledgment form to be completed by new volunteers and contractors.

The following actions were taken by the facility for corrective action #2: At this time, the auditor is unable to determine if there is improvement in maintaining new onboarding files for volunteers and contractors due to the suspension of onboarding new volunteers and contractors at the facility due to Covid-19.

Corrective Action #1

The intent of the corrective action was to ensure that volunteers and contractors were provided appropriate training in the agency's PREA Policy 2.13.

Corrective Action #2

The intent of the corrective action was to ensure that there was improvement in the maintenance of the contractors and volunteer files.

Based on the information provided to date, the facility substantially meets the standard.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13.IV.A.2.a-b. 2. Stevenson House Detention Center Handbook p. 2 3. Stevenson House Detention Center Handbook- Spanish 4. Intake Process Form 5. Youth PREA Orientation “PREA and What You Need to Know” 6. PREA Phone Instruction-Spanish Interviews: 1. Intake Staff 2. Random Youth Site Review: 1. Intake Process- Copy of Footage 2. Youtube Video “PREA and Sexual Education for Residents in a Confinement Facility” Findings (by Provision): 115.333 (a): 1-3 According to DYRS Policy 2.13.IV.A.2.a-b, all youth in secure care shall receive PREA orientation and/or training. Specifically, the policy states that during the intake process, youth shall receive information explaining the zero-tolerance rule regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Six of the random staff that are responsible for intake detailed that youth receive information about the agency’s zero-tolerance policy during the intake process. Also, youth are verbally provided information on how to report incidents or suspicions of sexual abuse and sexual harassment. At the end of the intake process, youth sign a document confirming receiving information. Further it was explained, all intakes including those from other facilities obtain information about the agency’s zero-tolerance policy on sexual abuse and sexual harassment from the PREA intake orientation. According to the PREA compliance manager, youth watch a video from Youtube pertaining to PREA. Based on information obtained from the PREA compliance manager, it is believed that the video is titled, “PREA and Sexual Education for Residents in a Confinement Facility.” The video is age appropriate for youth. There was ambiguity regarding whether the video was shown during the intake process or comprehensive PREA orientation. During the onsite audit, the auditor did not inquiry about the use of a student handbook at the facility. During post onsite review, the auditor requested a copy of the facility’s handbook which is generally provided to youth during intake. On page seven of The Stevenson House Detention Center Handbook, the auditor discovered there is information pertaining to sexual abuse. The handbook does not have a designated section explaining PREA. There is no information provided about zero-tolerance or sexual harassment. Review of the handbook, the auditor determined there is only one way listed to report sexual abuse. Youth were asked if they had received the facility’s rules against sexual abuse and sexual harassment during the intake process. Of the 16 youth, there were 15 corroborated they did receive the rules against sexual abuse and sexual harassment. Due to the 2-youth entering the facility were Covid diagnosed, the auditors elected to receive footage of the intake process. The footage lacks audio, so the auditors were unable to determine whether there was a discussion related to PREA. During the file review, the auditors located several Orientation Process Forms which listed PREA as a training category. Only five out of the eleven youth files contained the form that youth received PREA orientation at intake. Youth and staff are required to sign this document. The facility does not meet compliance in this provision. 115.333(b)-1 According to DYRS Policy 2.13.IV.A.2.a-b, all youth in secure care shall receive PREA orientation and/or training. The policy

states that within 10 days of the intake the secure care program is responsible for implementing a more detailed education. Within the supplemental files of the OAS, the auditors were provided three documents.

1. What is PREA?
2. Prison Rape Elimination Act (PREA) and What You Need to Know."
3. Division of Youth Rehabilitative Services PREA Refresher: PREA Basics.

It was unclear whether these documents were provided during the initial PREA training or the comprehensive PREA Training. "PREA and What You Need to Know" required a signature from both the youth and a witness. One of the documents appeared to be a document that would be utilized for staff refresher training.

The auditor inquired of the youth if they were informed about their right not to be sexually abused or sexually harassed. Of the sixteen-youth interviewed, there were fifteen youth who affirmed that they were aware. The auditor questioned the youth if they were aware of how to report sexual abuse and sexual harassment, and the fifteen-youth said that they were aware. Additionally, they were aware that they had a right not to be punished for reporting sexual abuse or sexual harassment. Youth were asked when they received the information. The youth stated that they learned it during intake. The auditor could not determine through interview with random youth if they had received comprehensive training.

115.333(c)-1-4

During the review of the 11 youth files, there were only four files that contained evidence that youth received comprehensive PREA training. Only five out of the eleven youth files contained evidence that youth received PREA orientation at intake.

The agency policy does not specifically state that youth transferred from another facility shall receive PREA training, rather it says that all youth in secure care will receive PREA training. Stated in DYRS Policy 2.13IV.A.2.a, all youth in secure care shall receive PREA orientation and/or training. The intake staff stated that all intakes are provided PREA orientation in the same manner whether the resident comes from the community or transferred from another facility.

115.333(d)-1-5

Resident PREA education is available for limited English proficient youth. Spanish is the second language spoken in Delaware. The following items are available at the Stevenson House Detention Center in Spanish:

1. Stevenson House Detention Center Handbook-Spanish
2. PREA Safety Guide-Spanish

Upon auditor's request, the Spanish version of the handbook was provided in the supplemental files of the OAS. Based on the English version of the handbook, there is limited information provided pertaining to sexual abuse, and there is no specific information pertaining to PREA. There is an existing contract to provide interpretative and translation services for limited English proficient youth. For youth that are deaf, there are vendors on the state contract that can provide sign language services at no cost to the resident. Stevenson House Detention Center has the capability to enlarge PREA training materials for youth that are visually impaired. DYRS Policy 2.13.IV.B.6, ensures that youth with disabilities are given the same information to prevent, detect, and respond to sexual abuse and sexual harassment in a format supportive of the disability. The facility substantially meets the provision.

115.333(e)-1

The auditor determined that the facility inconsistently maintains documentation of resident participation in PREA related training. During review of the student files, there was limited documentation maintained in resident files of PREA education. Inconsistently, the auditors located the documentation for PREA orientation being completed at intake and documentation of the completion of comprehensive PREA training. The facility does not meet compliance in this provision.

115.333(f)-1

Stevenson House Detention Center inconsistently ensure that the agency's PREA policy is continuously and readily available. During the site review, the auditor observed that there were limited PREA related posters around the facility and there were no victim advocacy posters. In part, some areas items needed to be removed for fogging due to Covid. The auditor did not locate any brochures on sexual safety or victim advocacy at the entrance or throughout the building. All information pertaining to contacting the Child Abuse Hotline needed to be updated.

The evidence shows that the Stevenson House Detention Center inconsistently provides information at the time of intake about the agency's zero-tolerance and how to report incidents or suspicions of sexual abuse and sexual harassment. The facility has demonstrated that the facility does not consistently provide comprehensive PREA training within 10 days of intake. The DYRS 2.13 does not specifically state that youth that are transferred are provided PREA training. The agency does provide PREA education in formats that is accessible to all youth including students that are limited English proficient or

disabled.

Based on the analysis, the facility requires corrective action.

Corrective Action:

1. Provide comprehensive PREA Orientation within 10 days of intake in accordance with PREA Standard 115.333(b).
2. Cite in DYRS Policy 2.13 that youth who are transferred from one facility to another receive PREA training in accordance with PREA Standard 115.333(c)-4.
3. Cite in DYRS Policy 2.13 that youth are to receive both PREA orientation at intake and comprehensive PREA training within 10 days of intake.
4. Provide accessibility to information pertaining to the prevention, detection, reporting, and the response to sexual abuse and sexual harassment.

Best Practice Recommendation:

1. Update the Stevenson House Detention Handbook with information pertaining to the PREA mandates both in English and Spanish.

Verification of corrective action since the audit-

In response to the corrective action, the facility provided documentation to the auditor through the supplemental files. For corrective action #1 rosters of youth completion of comprehensive PREA training was uploaded on 7/22/2021, 7/30/2021, and 8/6/2021. For corrective action #2 and corrective action #3, the PREA Policy 2.13 revision was uploaded on the agency website and to the OAS supplemental files on 5/13/21. For corrective action #4, photos were uploaded designating the location of the dissemination of materials pertaining to the prevention, detection, reporting, and the response to sexual abuse and sexual harassment.

The following actions were taken by the facility for corrective action #1: the facility provided documentation which demonstrated evidence of all residents being brought up to date on the PREA comprehensive training on 7/22/2021. To further assess the facility's practice of providing the PREA comprehensive training within 10 days of resident's admission, the auditor requested evidence of PREA orientation training and comprehensive PREA training documentation of residents admitted after 7/22/2021. Documentation was uploaded which showed improvement in providing comprehensive PREA training within the 10 day requirement. The facility provided evidence of comprehensive PREA training being provided within 10 days of admission to the facility on 7/30/2021 and 8/6/2021.There were 9 samples uploaded of both PREA orientation during intake as well as comprehensive PREA training occurring within 10 days. On 7/22/2021, the auditor received an email with a plan to address adherence to the standard. The plan was devised by the PREA coordinator to ensure that the time limits were consistently met by the all DYRS facilities. The plan going forward consist of a calendar invite for every Monday to ensure that any newly admitted youth within the week would receive the comprehensive training within 10 days of admission. Evidence of the calendar invite was provided in the OAS.

The following actions were taken by the facility for corrective action #2: the agency revised the PREA policy. Cited in the agency's revised PREA Policy 2.13.IV.C.2.c states that any resident who transfers to a different facility must immediately be taught about any difference in the policies or procedures at the new facility. Uploaded to OAS, the facility provided documentation that all staff were trained on the revisions to the policy.

The following actions were taken by the facility for corrective action #3: the agency revised policy. Cited in the agency's revised PREA Policy 2.13.IV.C.2.b All youth in secure care must receive PREA orientation and comprehensive training. Within ten days of arrival, residents must be taught (in person or through video): 1) they have the right to be free from sexual abuse and sexual harassment; 2) they have the right to be free from retaliation for reporting such incidents; and 3) how the agency responds to such incidents. Uploaded to OAS, the facility provided documentation that all staff were trained on the revisions to the policy.

The following actions were taken by the facility for corrective action #4: the auditors were provided pictures of the locations of informational material pertaining to accessibility to the prevention, detection, reporting, and the response to sexual abuse and sexual harassment at the facility.

Corrective Action #1

The intent of the corrective action was to ensure that the facility's practice is to provide all residents with PREA comprehensive training within 10 days of admission. The facility brought up to date all residents on 4/20/2021. Additionally, the facility provided auditor documentation of the improvement of the practice of providing PREA comprehensive training. Additionally, a plan was devised to ensure that youth was receiving the mandated comprehensive PREA training within the

time limits.

Corrective Action #2

The intent of the corrective action was to ensure that DYRS staff knowledge is consistent with all staff involved in the transfer of residents from other locations. Additionally, to ensure that staff educate residents of any differences in policies and procedures pertaining to PREA when residents are being transferred to other facilities.

Corrective Action #3

The intent of the corrective action was to ensure that DYRS staff knowledge is consistent in the adherence of comprehensive PREA training to youth within 10 days of admission to Stevenson House Detention Center.

Corrective Action #4

The intent of the corrective action was to ensure that youth consistently have accessibility to information pertaining to the prevention, detection, reporting, and the response to sexual abuse and sexual harassment.

Based on the review of the information received to date, the auditor finds that the facility substantially meets compliance with this standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.1.f-h 2. PAQ 3. Certificates for PREA: Investigating Sexual Abuse in a Confinement Setting 4. Certificate for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigation 5. NIC Website- https://nicic.gov/specialized-training-investigating-sexual-abuse-confinement-settings 6. Certificate: PREA Investigations Training hosted by the Delaware Department of Corrections Interviews: 1. Institutional abuse investigator (IA) 2. Facility PREA investigator Findings (by Provision): 115.334 (a): DYRS Policy 2.13.IV.1.f-h does not specifically state that investigators are to be trained in conducting sexual abuse investigations in confinement settings. Cited in the policy, all department staff working directly with or monitoring programs/services of youth in secure and community services must receive PREA training. Further cited in the policy, training will include, but not be limited to, complaint recipient responsibility, how to report an incident, coordinated responses duties, investigations, and how to access victim services. The training topics are aligned to topics that are covered in either a comprehensive PREA training or refresher for all staff. DSCYF Policy 208 was provided in the PAQ. This policy also does not require that investigators be trained in conducting sexual abuse investigations in confinement settings. The policy outlined the procedures to follow investigating physical/sexual abuse or serious neglect by a DSCYF employee, contractor, and or volunteer. Review of training documents provided through the PAQ, indicated there were three certifications for two Institutional Abuse investigators. There were two certificates for PREA: Investigating Sexual Abuse in a Confinement Setting and there was one certificate for PREA: Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations. Both trainings were three-hour online trainings. The trainings were provided by the National Institute of Corrections Training (NIC). During the onsite audit, the auditors were given a certificate for the facility PREA investigator. The course was hosted by the Delaware Department of Correction. The course was offered in December of 2016. Though the agency does not require investigation training for sexual abuse in confinement, there is a practice of having investigations completed by investigators that have had the training. The agency substantially meets this provision. 115.334 (b)-1 There were two investigators interviewed. IA investigator was Institutional Abuse investigator and the other was a facility PREA investigator. One of the investigators stated that they had received the specialized training in conducting sexual abuse investigations in confinement settings. It was stated by the investigator that the training received included securing the crime scene, criteria for substantiating a case, collecting circumstantial evidence, and interviewing of witnesses and alleged perpetrators. According to the website, the following topics are covered in the three hour online training: • PREA Update and Standards Overview • Legal Issues and Liability • Culture • Trauma and Victim Response • Medical and Mental Health Care • First Response and Evidence Collection • Juvenile/Adult Interviewing Techniques • Report Writing • Prosecutorial Collaboration The facility PREA investigator had difficulty recalling the elements of the course provided by the Delaware Department of Corrections. According to the certificate, the Delaware Department of Correction: PREA Investigations Training included the following:

- Special issues related to conducting sexual assault investigations in confinement settings.
- Basic Trauma Theory
- Maladaptive coping skills related to trauma exposure.
- Report writing evidence collection.
- Crime scene protection
- Use of Miranda and Garrity

Both trainings provide the required elements as it relates to investigating sexual abuse in a confinement setting. The agency substantially meets this provision.

115.334(c)-1-2
Stevenson House Detention Center maintains copies of the certificates for PREA investigators. Uploaded on the PAQ, there were three certificates of the trainings completed by the IA investigators. During the onsite audit, the facility PREA investigator provided a copy of a certificate of completion from the Delaware Department of Corrections: PREA Investigations Training. The facility provided documentation for all three investigators. The agency substantially meets this provision.

115.334(d)-1
Auditors are not required to audit this provision.

The evidence shows that there is an existing policy that requires PREA training for all employees. Mentioned in the policy as one of the topics covered in the PREA training is investigations. The policy does not specifically direct that investigators are required to get training in conducting sexual abuse investigations in confinement settings. Verified from the certificates obtained from the Stevenson House Detention Center, all three of the investigators have received PREA training in conducting sexual abuse investigations in confinement settings.

Best Practice Recommendations:

1. PREA Policy 2.13 add PREA Investigators are required to complete PREA training in conducting sexual abuse investigations in confinement settings.
2. Refresher training for investigator that participated in Delaware Department of Corrections PREA Investigations Training in 2016.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.III.A 2. DYRS Policy 2.13IV.A.1. 3. Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault 1/4/2021- Bayhealth Hospital, Sussex Campus Interviews: 1. Medical Staff 2. Mental Health Staff Findings (by Provision): 115.335 (a): -1 DYRS Policy 2.13.III.A includes the medical and mental health personnel as staff. The policy states that staff for the purpose of this policy, is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends and other visitors). Further within the Policy 2.13IV.A.1. it is quoted that all staff working directly with or monitoring programs/services of youth in secure care and community services must receive PREA training. There is no specific policy related to medical and mental health practitioners receiving specialized training. The specialized training includes: 1. Detection and the assessment of signs of sexual abuse and sexual harassment. 2. The preservation of physical evidence of sexual abuse. 3. Responding effectively and professionally to juvenile victims of sexual abuse and sexual harassment 4. How and whom to report allegations or suspicions of sexual abuse and sexual harassment. Documented on the PAQ, there were six medical staff that worked regularly at the Stevenson House Detention Center. There are six medical and mental health practitioners that received the PREA specialized medical and mental health training. The auditors interviewed a mental health practitioner and a medical practitioner. In both cases, the staff members recalled receiving specialized training. Both medical and mental health staff were able to recall some topics from the training. The agency does meet this provision. 115.335(b)-1 The medical staff at the Stevenson House Detention Center does not perform forensic medical examinations. For the Stevenson House Detention Center, forensic examinations are performed at the Bayhealth Hospital, Sussex Campus. In existence, there is an Affirmation of Compliance with Forensic Examinations Standards for Sexual Assault between DYRS and the Bayhealth Hospital, Sussex campus. During the interview, medical staff stated that they do not perform forensic medical examinations at the Stevenson House Detention Center, and it was added that the resident would be taken to the above-named hospital. The agency does meet this provision. 115.335 (c)-1 The agency maintains copies of the specialized training for medical and mental health staff certificates. These were made available through the PAQ. The required training certificates were not provided in the PAQ. The agency does meet this provision. 115.335 (d)-1 DYRS Policy 2.13.III.A includes the medical and mental health personnel as staff. The policy states that staff for the purpose of this policy, is defined as any Department employee, volunteer, contractor, official visitor, or other agency representative (exclude family, friends and other visitors). Further within the Policy 2.13IV.A.1. it is quoted that all staff working directly with or monitoring programs/services of youth in secure care and community services must receive PREA training. There were six medical staff that worked regularly at the Stevenson House Detention Center. There were no medical staff that received the training mandated for employees by PREA Standard 115.331. All six medical staff received the specialized PREA training for medical and mental health staff. The agency does not meet this provision.

The evidence provided that the DYRS Policy does not refer to specialized PREA training for medical and mental health practitioners. All medical and mental health practitioners are not trained in the PREA training referred in PREA Standard 115.331.

Based upon this analysis, the facility does not meet PREA Standard 115.335 and corrective action is required.

Corrective Action:

1. Add to DYRS Policy 2.13 the requirement of medical and mental health practitioners to receive specialized medical and mental health training in accordance with PREA Standard 115.335(a).
2. Medical/mental health practitioners complete PREA training in accordance with PREA Standard 115.331(a).

Verification of corrective action since the audit-

In response to the corrective action, the facility provided documentation to the auditor through the supplemental files of the OAS. For corrective action #1, the agency provided a copy of the revised PREA Policy 2.13 on 5/13/2021. For corrective action #2, on 6/1/2021, the PREA coordinator provided certificates for both PREA training and specialized medical and mental health training.

The following actions were taken by the facility for corrective action #1: the agency provided a revision to PREA Policy 2.13.IV.C.3.b which states Medical and mental health staff are required to complete specialized training that includes how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment and how and whom to report allegations or suspicions of sexual abuse and sexual harassment. This is in addition to the PREA training given to all employees. The facility provided documentation that all staff were trained on the revisions to the policy.

The following actions were taken by the facility for corrective action #2: the PREA coordinator provided 4 certificates of medical and mental health practitioners that completed the PREA training required by all employees.

Corrective Action #1

The intent of the corrective action was to ensure that agency policy requires that medical and mental health practitioners receive specialized medical and mental health training in accordance with PREA standard 115.335(a).

Corrective Action #2

The intent of the corrective action was to ensure that medical and mental health practitioners complete the PREA training in accordance with PREA standard 115.331(a).

Based on the information provided to date, the facility is substantially compliant on this standard.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV B, 2, (Revised 6/29/17). 2. PREA Risk Assessment Interviews: 1. Staff responsible for risk screening 2. Resident 3. PREA coordinator 4. PREA compliance manager Findings (by Provision): 115.341 (a): In the PAQ, the agency reported that they have a policy that requires screening upon admission to a facility or transfer to another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents within 72 hours and reassessed periodically throughout their confinement. Agency relies on PREA Policy 2.13 Prevention Section IV B, 2, that outlines classification or assessment tools will be utilized to determine supervision needs of youth for the protection of victims and those known to be perpetrators. As written, the policy does not state that it requires screening upon admission to a facility or transfer to another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents, require that screening is within 72 hours of intake or that residents are reassessed periodically. The facility reported in the PAQ, 136 residents that entered the facility in the past 12 months whose length of stay was 72 hours or more was screened for risk of sexual victimization and risk of sexually abusing others was completed within 72 hours of admission. At the time of the onsite audit there were 31 residents admitted to the facility. The auditors reviewed 14 resident PREA screening. In review, 10 out of 14 residents that were screened at intake was completed within 72 hours of admission to the facility. The PREA risk assessment form used provides that the resident is being screened for victimization but does not clearly outline that it is being used to screen for abusiveness. During interviews with residents,14 out of 14 four out of 16 residents recall being asked questions at intake on the first day but did not recall being asked questions related to sexual abuse. During interviews with staff that are responsible for risk screening, staff stated that there are mental health and medical staff screen residents upon admission to the facility. Staff indicated that they screen Monday thru Friday and medical ensure residents are screened and mental health would follow up on their return onsite. Staff indicated they use files and the FOCUS database to conduct initial risk screening. When asked how often are resident's risk levels assessed, staff stated risk levels are reassessed every six months. In the PAQ the facility reported the average length of stay was 38 days. At the time of the onsite audit, two of the 16 residents had been at the facility for more than six months. Both residents were reassessed with six months that confirms that residents are reassessed periodically throughout their confinement. The evidence shows that the agency policy is missing key components of the provision that requires for screening upon admission or transfer and periodic reassessments. Although it was evident that residents are screened, it is not clear from the assessment if residents are screened for risk of abusiveness towards others. Not all residents were screened within 72 hours of intake as required. Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required. 115.341 (b): In the PAQ, the facility reported that a risk assessment is conducted using an objective screening instrument. The facility provided a PREA risk assessment for review. The auditor reviewed the PREA risk assessment and determined that the screening instrument was not objective. As written, the current PREA risk assessment does not ascertain information about abusiveness, manner of identification as lesbian, current charges and offense history, physical size and stature as outlined in the standard. The risk assessment does not have a scoring mechanism or scoring guideline that would determine the resident's overall risk of sexual victimization or risk of abusiveness towards others. During interviews with staff that conduct risk screening, the staff stated that they use a paper

version of what they have in FOCUS and it has screening questions.

The risk assessment is comprised of a series of questions and information about the resident but does not yield an outcome that could be used to inform staff of supervision needs for housing, bed, education and program placement.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.341 (c):

The auditor was able to review the PREA risk assessment provided by the agency. Upon review, four of the eleven key components of the initial PREA risk assessment screening is missing.

1. Residents prior history of sexual abusiveness.
2. Residents current charges and offense history.
3. Gender non-conforming appearance or manner of identification as lesbian.
4. Physical size and stature.
5. The agency has included additional components not prescribed in the PREA standard for assessing risk.

6. Prior history of “inappropriate behavior”.
7. Current sex related charge and ”sexual” offense history.
8. How does student identify their gender? (female, male, transgender, other).
9. How does the student describe their sexual orientation? (heterosexual, homosexual, bisexual, questioning, other.
10. “Age appropriate” level of emotional and cognitive development.
11. “Small” physical size and stature.
12. History of traumatic experiences.

During an interview with staff responsible for conducting risk screening, when asked what does the initial risk screening consider, staff reported residents more at risk or vulnerable, we can flag in FOCUS.

The evidence shows that not all of the criteria for the PREA risk screening are included in the risk assessment instrument and staff was not able to provide all the elements required.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.341 (d):

PREA Policy 2.13 Section IV titled prevention B. 2, outlines that classification or assessment tools will be utilized to determine supervision needs of youth for the protection of victims and those known to be perpetrators.

During an interview with staff that conduct risk screening, when asked how is information ascertained, staff stated case files and information in the FOCUS database. It is noted that the mental health staff conduct risk assessment screening at intake. It is not clear if the staff that perform risk assessments ascertain information from classification or court records.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.341 (e):

In the PAQ, the provision requires that an agency implement appropriate controls on the dissemination within the facility of the responses to questions in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents. During an interview with the PREA coordinator, when asked has the agency outlined who should have access to a resident’s risk assessments within the facility in order to protect the resident’s information from exploitation, staff stated risk assessment access through FOCUS is with the psychologist. They have all the details of who is at risk and give details. During an interview with staff that conduct risk screening, staff stated a status report goes out every day to designated staff, but it is not accessible in FOCUS. Department Analyst stated that the mental health staff and the superintendent has access to risk assessments. During an interview, the Information System Specialist/FOCUS liaison stated any cases for PREA comes in to the intake portion of FOCUS and only the psychologist has access to the PREA risk assessment. Internal Affairs and the PREA coordinator have read-only access. The superintendent and PREA compliance manager would not be able to see it. During an interview with the PREA compliance manager, he confirmed that mental health has access and provides the risk and status. During the onsite review, the auditor was able to determine that access to information in FOCUS was granted based on the staff person’s position.

The evidence shows that the agency has controlled the level of access that each staff has in the FOCUS database to control and protect sensitive information.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Revise Policy 2.13 PREA Section IV Section IV B, 2, to include requires screening upon admission to a facility or transfer to another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. Revise PREA policy to include, require that screening is within 72 hours of intake and require that residents are reassessed periodically.
2. Revise PREA Risk assessment form to include history of sexual abusiveness.
3. Develop a scoring mechanism or scoring guideline that would determine a resident's overall risk of sexual victimization or risk of abusiveness towards others for all of the questions on the PREA Risk Assessment.
4. Revise PREA risk assessment to include:
    a. Residents prior history of sexual abusiveness.
    b. Residents current charges and offense history.
    c. Gender non-conforming appearance or manner of identification as lesbian.
    d. Physical size and stature.
    e. Train staff on revised policy and risk assessment.
    f. Document staff have received training.

Best Practice Recommendations:

Revise PREA Policy 2.13 to include how many days after initial risk assessment that a reassessment is to be completed.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/15/21, 7/16/21, 7/22/21, 7/28/21 in response to the corrective action recommendations.

1. Provided revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21). (11 pages).

2. Revised PREA Policy 2.13 Staff Training Roster (8 pages).

3. Revised PREA Policy 2.13 Staff Training Roster (2 pages).

4. Revised PREA Risk Assessment form (2 pages).

5. Developed PREA Recommendation Decision Tree (2 pages).

6. PREA Recommendation Decision Tree Staff Training acknowledgement (2 pages).

The following action were taken: DYRS revised their PREA policy 2.13 on 5/13/21 to reflect that the PREA risk assessment is used to determine risk of sexual abuse victimization or sexual abusiveness toward other residents and will inform housing, bed, work, education and program assignments for all residents. Upon intake, staff will ask the youth their gender identify. This information will be used for immediate safety and housing decisions. The formal PREA risk assessment is completed by facility clinical staff within 72 hours of a new admission or a transfer from another facility. Residents are reassessed every six months thereafter. The agency revised the PREA Risk assessment form to include history of sexual abusiveness, resident's current charges, offense history, gender non-conforming appearance or manner of identification as lesbian, and physical size and stature. The agency developed a decision tree that would determine a resident's overall risk of sexual victimization or risk of abusiveness towards others for all of the questions on the PREA Risk Assessment

Corrective Action #1

The intent of this corrective action was to ensure that upon admission or transfer to another facility, residents were screened within 72 hours for risk of sexual victimization and risk of sexual abusiveness towards other residents. Residents are reassessed periodically. The facility provided 10-page training roster that included 65 staff signatures acknowledging that they were trained on the agency's revised PREA policy 2.13. This satisfies the auditor's corrective action requirement.

Corrective Action #2, #4

The intent of this corrective action was to ensure that the PREA risk assessment included the factors required as outlined in the standard for screening residents for risk of victimization and risk of abusiveness towards others. The agency took action and provided the auditor a revised risk assessment screening form that includes all the factors consistent with the standard. Specifically, PREA Risk assessment screening form was revised to include screening for risk of abusiveness, current charges and offense history, gender non-conforming appearance or manner of identification as lesbian, physical size and stature. This risk ssessment satisfies the auditor's corrective action requirement.

	Corrective Action #3 The intent of this corrective action was to ensure that the risk assessment was conducted using an objective screening instrument that determined an overall risk of sexual victimization or risk of abusiveness towards other residents. The agency developed a PREA Recommendation Decision Tree (2 pages) that was objective and provided an assignment decision based on the responses to the risk assessment screening factors. Staff conducting risk assessment screening was provided training on how to use the objective screening instrument and decision tree to inform staff on housing, bed, work, education and program assignments. The auditor reviewed two training acknowledgements from staff that indicated they had been trained on the PREA Risk Assessment recommendations and decision tree and acknowledged that they understood what was discussed and documents provided. This training satisfies the auditor's corrective action requirement. Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 Sections IV (Revised 3/5/19). 3. Resident Files Interviews: 1. PREA compliance manager 2. Staff responsible for risk screening 3. Superintendent 4. Medical and mental health staff Site Review Observation: 1. Observation during onsite review of physical plant Findings (by Provision): 115.342 (a): In the PAQ, the facility reported that they use information from the risk screening to form housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The agency relies on PREA Policy 2.13 Section IV Titled protection B, 3, that outlines protective supervision includes housing decisions, movement throughout the facility, all routine and non-routine activities. LGBTQI Policy 2.20 Sections IV Titled special considerations E, 1, outlines that DYRS shall use information obtained in intake and referral documentation and the mental health assessment to make housing, bed, program, education and work assignments for youth with the goal of keeping all youth safe and free from sexual abuse and sexual assault. During interviews with the PREA compliance manager, when asked how does the facility use information from the risk screening during intake to keep residents safe and free from sexual abuse, staff stated Mental Health provide the risk and status. If it is a high risk, they will note it. If they had a background, they let us know if they had a background. During interviews with staff responsible for risk screening, when asked how does the facility use information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment, staff stated they provide the information to administration to keep away from those that are predator and kids that do not need to be together. The auditor was able to determine that residents identified as having a PREA risk related factor are not provided any specific recommendations as it relates to housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The evidence shows that the facility has not demonstrated how the information obtained from the risk assessment is used to inform them of housing, bed, education and program assignments that would keep residents safe and free from sexual abuse. The facility will need to develops an objective screening instrument as required in 115.341, so they will be better informed on what housing, bed, education and program assignments are safe for all residents. Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required. 115.342 (b): In the PAQ, the facility reported they have a policy for residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The policy also requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. LGBTQI Policy 2.20 Sections IV Titled special considerations E, 1, c, outlines that LGBTQI residents may be isolated from others only as a last result and only until less restrictive means of keeping resident safe can be arranged and during any period of isolation resident shall not be denied daily large-muscle exercise, legally required programming or special education services.

In the PAQ, the facility reported that in the past 12 months there was no residents at risk of sexual victimization placed in isolation that would have been denied access to daily large-muscle exercise, legally required educational programming or special education services.

During interviews with mental health and medical staff, when asked do residents in isolation receive visits from medical and mental health care, staff stated every day. Any in the Covid Unit, we operate through telehealth zoom for business skype every day except Saturday. Residents are seen within 72 hours. During holidays (Thursdays or Friday), medical staff would begin that process. During interviews with the superintendent, when asked are residents only isolated from others as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged, staff stated we have not had any incidents but if we did it would only be until an alternative arrangement could be made.

During the onsite review, the auditor went into all areas of the facility which included administration building, visiting housing, classrooms, maintenance, food service, laundry, library and did not observe any segregated housing units or isolation rooms. A review of 11 resident files did not reveal that residents were placed in isolation. The auditor was able to review additional information provided by mental health that did not provide a clear determination of risk that would inform the facility to place a resident into isolation in the facility.

The evidence shows that the facility has a policy to isolate residents at risk of sexual victimization. The auditor's observation of the facility did not reveal any type of segregated housing or isolation room, cell or housing that would confirm that the facility isolates residents. There is no verifiable information on how the facility determines when a resident is at risk of victimization that would prompt the facility to move a resident to isolation. The facility will need to develop an objective screening instrument as required in 115.341, so they will be better informed on residents that may be at risk of victimization that would require isolation.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.342 (c):

In the PAQ, facility reported they prohibit placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. Also, the facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The agency relies on LGBTQI Policy 2.20 Section IV E, 1, d, that outlines LGBTQI youth shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall DYRS consider lesbian, gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive.

During an interview with the PREA coordinator, when asked does the facility have special housing units for lesbian, gay, bisexual, transgender or intersex residents, staff stated they was unaware. During interview with the PREA compliance manager, when asked does the facility have special housing units for lesbian, gay, bisexual, transgender or intersex residents, staff stated no.

At the time of the onsite audit, the auditor reviewed resident files and housing unit placements for all residents. There were no residents placed in a housing assignment solely based off of their identification status. There were no special housing units solely for LGBTQI residents.

Based on the evidence the facility does not have a special housing for LGBTQI residents or consider identification status as a likelihood of being sexually abusive this was verified by policy, interviews, resident files and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (d):

In the PAQ, the facility reported they make housing and program assignments for transgender or intersex residents in a facility on a case-by-case basis.

Agency LGBTQI Policy 2.20 Section IV E, 1, d, outlines that DYRS shall consider on a case-by-case basis whether to assign a transgender or intersex youth to a facility and whether placement would ensure the youth's health, safety or present a management or security problem.

During an interview with the PREA compliance manager, when asked how does the facility determine housing and program assignments for transgender or intersex residents, staff indicated that all residents get the same programs.

Prior to the onsite review, the auditor reviewed the facility website and obtained information that the facility housed both male and female residents. During the onsite review, the auditor observed only male residents at the facility. There were no female residents at the facility during the onsite audit, but the auditors were able to complete a review of the housing unit that

was designated for female residents.

The evidence shows that the facility makes housing and program assignments for transgender and intersex residents on a case-by-case basis which is verified by PAQ, policy, interview, website and onsite review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (e):

In the PAQ, the facility reported placement and programming assignments for each transgender or intersex resident shall be assessed at least twice each year to review any threats to safety experienced by the resident.

Agency LGBTQI Policy 2.20 Section IV E, 1, f, outlines that placement and programming assignments for each transgender or intersex youth shall be reassessed by the interdisciplinary team at least twice each year to review any threats to safety experienced by the youth.

During an interview with the PREA compliance manager, when asked how often are placement and programming assignments for each transgender or intersex resident reassessed to review any threats to safety experienced by the resident, the staff indicated that they would reassess but did not indicate how often.

During the onsite audit, the auditor reviewed 11resident files and was able to determine there were no residents that identified as transgender or intersex.

The evidence shows that each transgender or intersex resident shall be assessed at least twice each year which is verified through PAQ, policy, interviews and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (f):

In the PAQ, A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

Agency LGBTQI Policy 2.20 Section IV E, 1, g, outlines that a transgender or intersex youth's views with respect to his or her own safety shall be given serious consideration.

During an interview with the PREA compliance manager, when asked are transgender or intersex residents own views with respect to his or her own safety given serious consideration when making placement and programming assignments, staff stated yes. During an interview with staff responsible for risk screening, when asked are transgender or intersex residents own views with respect to his or her own safety given serious consideration in placement and programming assignments, staff stated yes,

The evidence shows that each transgender or intersex resident views are considered which is verified by PAQ, policy, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (g):

In the PAQ, transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Agency LGBTQI Policy 2.20 Section IV F, outlines that transgender and intersex youth shall be given the opportunity to shower and use the bathroom separately from other youth.

During an interview with the PREA compliance manager, when asked are transgender or intersex residents given an opportunity to shower separately from other residents, staff stated yes on a weekly basis and on clinicals if we have any residents that are transgender or intersex.

During an interview with staff responsible for risk screening, when asked are transgender or intersex residents given the opportunity to shower separately from other residents, staff stated yes.

During the onsite review, the auditor observed the showers are separate and all residents shower separately. Only one resident may shower at any given time.

The evidence shows that each transgender or intersex resident are given an opportunity to shower separate from other residents which is verified by PAQ, policy, interviews and onsite observation.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (h):

In the PAQ, the facility reported there were no residents isolated pursuant to paragraph b of this section in the past 12 months that required the facility to document a concern of a resident's safety.

During an interview, the superintendent stated they have not had an incident where a resident was isolated at the facility.

During the onsite review, the auditor did not observe any segregated housing units or isolation rooms. A review of 11 resident files did not reveal that residents were placed in isolation. The auditor's observation of the facility did not reveal any type of segregated housing or isolation room, cell or housing that would confirm that the facility isolates residents as outlined in this provision.

The evidence shows the facility does not isolate residents at the facility which was verified through interview, observation, and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.342 (i):

In the PAQ, every 30 days, the facility shall afford each resident described in paragraph h of this section a review to determine whether there is a continuing need for separation from the general population.

Agency LGBTQI Policy 2.20 Section IV E, I, outlines that every 30 days the facility shall afford each youth in isolation a review to determine whether there is a continuing need for separation from general population.

During an interview, the superintendent stated they have not had an incident where a resident was isolated at the facility.

During the onsite review, the auditor did not observe any segregated housing units or isolation rooms. A review of the resident files did not reveal that residents were placed in isolation. The auditor's observation of the facility did not reveal any type of segregated housing or isolation room, cell or housing that would confirm that the facility isolates residents as outlined in this provision.

The evidence shows the facility did not have an incident where a resident was isolated at the facility that would prompt a 30-day review. This was verified through interview, observation, and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. For 90 days, please provide weekly reports on housing, bed, education, and program placement of all residents that have been identified as a PREA risk pursuant to their risk assessment screening.
2. The facility will need to develop an objective screening instrument as required in 115.341, so they will be better informed on residents that may be at risk of victimization that would prompt isolation placement in isolation.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/16/21 and 7/28/21 in response to the corrective action recommendations.

1. Provided SHDC Census Report (62 pages).
2. Population Room Chart (141 pages).
3. PREA Risk Assessments (85 pages). (16 Risk Assessments)
4. Developed PREA Recommendation Decision Tree (2 pages).
5. PREA Recommendation Decision Tree Staff Training acknowledgement (2 pages).

The following action were taken: The agency developed an PREA recomendation Decision Tree that would inform staff on housing, bed, work education and program placement. The facility provided the auditor with census reports over a period of two months, general population room chart and PREA Risk Assessments.

Corrective Action #1, #2

The intent of this corrective action was to ensure that the risk assessment was conducted using an objective screening instrument that determined an overall risk of sexual victimization or risk of abusiveness towards other residents. The agency developed a PREA Recommendation Decision Tree (2 pages) that was objective and provided an assignment decision based on the responses to the risk assessment screening factors. This decision tree satisfies the auditor's corrective action requirement.

	The intent of this corrective action was to ensure that the risk screening is objective and information obtained from the objective risk assessment inform facility staff on housing, bed, work, education and program assignments. The auditor was provided census reports, population room charts and risk assessments. A review of 16 risk assessment reveal that residents are screened and the information from the risk assessment in conjunction with the decision tree does inform staff on how to place residents. A review of the population chart show that residents are placed in a single room with no roommate. This information satisfies the auditor's corrective action requirement. Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section C, 2, d (Revised 6/29/17). 2. Stevenson House Detention Center Handbook (Edited Version June 2017) 3. Title 10 Courts and Judicial Procedure 4. Division of Youth Rehabilitative Services Prisoner Professional Practices Reportable Events (Revised 6/27/14). 5. PREA Academy Training Manual 6. Agency Website www.kids.delaware.gov/yrs/prea Interviews: 1. Random staff 2. Resident 3. PREA compliance manager Site Review Observations: 1. Observation during onsite review of physical plant Findings (by Provision): 115.351 (a): In the PAQ, the agency reported that they provide multiple internal ways for residents to privately report sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provided Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section II titled Policy, (pp.1-3) which states that each facility will develop procedures that define the multiple ways for residents to privately report sexual abuse, sexual harassment and or retaliation by other residents but does not state developing ways for residents to privately report sexual abuse, sexual harassment and or retaliation by staff. This provision relates to resident reporting but the policy language in Section C, 2, d, reference how staff can report sexual abuse, harassment and staff neglect or violation of responsibilities that may have contributed to any of these incidents which is an element of the provision required for residents. The policy states how to confidentially access phones to report child abuse, how to initiate an emergency grievance, and tools necessary to make a written report. The policy provides youth can report any sexual contact between two youth or staff member and a youth to any staff, family member, probation officer, child abuse hotline or police agency, or the Child abuse hotline that serve as the designated 24-hour, seven days a week resource for youth to report while a resident of the program. The Stevenson House Detention Center Resident Handbook outlines several staff members that a resident could report to including a staff, nurse, supervisor, psychologist, and teachers. During the site review the auditor observed a telephone in each housing unit that was designated for the residents to call the hotline or family. The phone is located in a common area that is accessible to all residents and staff. This area provides very little privacy. During the onsite review, the auditor did not observe posting with the outside victim advocate number but did observe the PREA hotline number and information on how to report that included calling the hotline 1-800-292-9582 or 7735. The facility staff was updating the PREA hotline number for the residents to dial the PREA hotline. During Interviews with random staff, all 13 staff interviewed states that residents have multiple ways to report sexual abuse, sexual harassment, retaliation and neglect. Staff stated residents can report by notifying a supervisor, calling the PREA hotline, tell medical staff, tell a staff they trust. During Interviews the auditor asked all of the residents about the multiple ways they can make a report, 11 out of 16 stated they could call the PREA hotline, four out of 16 stated they could tell a family member or someone they trust, one out of 16 stated they did not know. The evidence shows that the facility has provided multiple ways for a resident to report sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities which was verified through handbook, policy, resident interviews, staff interviews, PREA phone and posting in the housing units. Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.351 (b):

In the PAQ, the agency reported that they provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency reported they do not provide information for immigrant services because the Delaware code prohibits detention of persons for civil immigration purposes.

The agency relies on PREA Policy 2.13, which states that a resident can make a complaint about sexual contact to a family member, child abuse hotline or police agency. The child abuse hotline is a designated 24-hour, seven days a week resource for residents to report abuse. In a memorandum of agreement, Survivors of Abuse in Recovery (SOARS) has partnered with the Department of Services for Children, Youth and Their Families to provide survivors of sexual abuse with emotional support services. The facility did not provide any information posted or in written format that would establish residents knew of the way in which they could contact SOARS a third-party victim advocate. The agency relies on Title 10 courts and judicial procedure 1007 that outlines that the facility does not detain residents for immigration purposes.

During Interviews, the PREA compliance manager stated residents have access to the phone, can call the hotline or a family member.

Post audit the auditors were able to speak with SOARS Executive Director, regarding their contact and services with the facility. Staff at SOARS confirmed that they have a memorandum of agreement with the facility to provide victim advocate for emotional support but have not had any contact with any residents at the facility. When asked how does a resident contact your agency, the SOARS staff stated they would call (302)-655-3953 and after the prompts select extension 1 for the intake department. When asked if the agency would receive a report of sexual abuse and sexual harassment from a resident at the facility, SOARS staff indicated they were not the appropriate party to report and it is not a part of their formal agreement. The agency stated that they are mandated reporters and if a resident provides a report, they would report it but their line is for someone seeking services.

During Interviews the auditor asked all of the Residents about at least one way they could report sexual abuse or sexual harassment that is not a part of the facility, 14 out of 16 said they would call their family member, two out of 16 said they knew who to call but did not provide a response. None of the residents knew about contacting SOARS at an outside agency.

During the onsite review, the auditor did not observe posting with the outside victim advocate number but did observe the PREA hotline number and information on how to report that included calling the hotline 1-800-292-9582 or 7735. The facility staff was updating the PREA hotline number for the residents to dial the PREA hotline.

The evidence shows that the facility has provided at least one way for a resident to report sexual abuse and sexual harassment which was verified through interviews, memorandum, policy, posting in the housing units. The agency does not provide information for consulate officials or relevant officials with Homeland Security because the court places a child in secure detention pending adjudication but not for civil immigration purposes.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.351 (c):

In the PAQ, the agency reported that they have a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Staff are required to document verbal reports within 24 hours.

The agency relies on PREA Policy 2.13 that outlines staff are required to report any allegations or instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to the child abuse hotline at 800-292-9582 and Reportable events Policy 2.12 requires staff to report in 24 hours. As written, the policy does not mandate that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties

During Interviews with random staff, 12 out of 13 staff stated if a resident alleges sexual abuse and sexual harassment they can do so verbally, in writing anonymously and through third parties, ten out of twelve staff said they would report and document this immediately, one out of 13 staff members did not know about making a report anonymously.

During Interviews with 16 Residents, 12 out of 16 residents said they knew they could make a report of sexual abuse or sexual harassment in person or in writing.

The evidence shows that the facility has a policy but it does not specifically mandate that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Interviews with staff are consistent with the requirements of the provision and interviews with residents verifies they knew they could make a report in person or in writing.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.351 (d):

In the PAQ, the agency reported that they provide residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents

Agency PREA Academy Training outlines that residents can make written reports verbally or in writing by telling any staff member, contractor or volunteer. Calling the DYRS reporting line #77 or ask someone else to report on their behalf.

During an interview, the PREA compliance manager stated that residents are made aware of the grievance process and the drop boxes that are checked in the hallway. Staff stated they stream lined the regular grievances process. PREA is not processed as a grievance but addressed immediately.

During the onsite review, the auditor did not observe posting with the outside victim advocate number but did observe the PREA hotline number and information on how to report that included calling the hotline 1-800-292-9582 or 7735. The facility staff was updating the PREA hotline number for the residents to dial the PREA hotline.

The evidence shows that the facility provides residents access to make written reports through staff, PREA hotline and grievance form which was verified through interviews, posting in the housing unit, grievance forms, and PREA academy training documents.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.351 (e):

In the PAQ, the agency reported that they established procedures for staff to privately report sexual abuse and sexual harassment of residents and staff are informed of these procedures through staff training.

The agency relies on PREA Policy 2.13 that states procedures must outline how staff can make reports of sexual abuse and sexual harassment confidentially. The agency provides that all staff are required to report any allegations and instances of non-consensual sexual acts, sexual abusive contact and sexual harassment to the Child abuse hotline 800-292-9582.

Agency PREA Academy Training outlines that staff can privately report through their chain of command, facility administrator, PREA coordinator, Child Abuse hotline 800-292-9582 and submitting an anonymous administrative report. A review of the agency website, provides information for the public to the Child Abuse hotline number 800-292-9582 or contact local law enforcement to report any sexual abuse or sexual harassment allegations regarding any DYRS youth.

During Interviews with 13 random staff, all 13 staff reported that they can privately report through the PREA hotline and to their supervisor.

The evidence shows that the agency has an established procedure for staff to privately report sexual abuse and sexual harassment of residents through calling PREA hotline, making an anonymous administrative report, talking with a supervisor, administrator or PREA coordinator which was verified through interviews, training documentation, postings, and agency website.

Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Revise the PREA Policy 2.13 Section IV C 1 a-b, to include a mandate that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties
2. Revise the PREA Policy 2.13 Section IV C, 2, c, to include staff neglect or violation of responsibilities that may have contributed to any of these incidents.
3. Establish a procedure or revise the PREA Policy 2.13 Section IV C to include ways for residents to privately report sexual abuse, sexual harassment and or retaliation by staff.
4. Train staff on the policy revisions.
5. Document staff training.

Best Practice Recommendations:

1. Educate residents on how to contact third-party Survivors of Abuse in Recovery SOARS.
2. Document that residents have been educated on SOARS.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/15/21 and 7/16/21 in response to the corrective action recommendations.

1. Provided revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21). (11 pages).
2. Revised PREA Policy 2.13 Staff Training Roster (8 pages).
3. Revised PREA Policy 2.13 Staff Training Roster (2 pages).

The following action were taken: DYRS revised their PREA policy 2.13 on 5/13/21 to reflect that staff accept any report of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse or sexual harassment and cases where sexual abuse, sexual harassment or retaliation might have happened because staff were neglectful or failed their responsibilities verbally to staff, by filing an emergency PREA grievance or by calling the child abuse hotline.

Corrective Action #1 through #5

The intent of this corrective action was to ensure that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties; to include staff neglect or violation of responsibilities that may have contributed to any of these incidents; to include ways for residents to privately report sexual abuse, sexual harassment and or retaliation by staff. The agency revised their PREA policy 2.13 to reflect that staff accept any report of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. Residents can privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse or sexual harassment and cases where sexual abuse, sexual harassment or retaliation might have happened because staff were neglectful or failed their responsibilities verbally to staff, by filing an emergency PREA grievance or by calling the child abuse hotline. The facility provided 10-page training roster that included 65 staff signatures acknowledging that they were trained on the agency's revised PREA policy 2.13. This satisfies the auditor's corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Stevenson House Detention Center Resident Handbook (June 2010) 3. Emergency Grievance Form Attachment B Policy 5.9 4. Youth Grievance Complaint Procedure Policy 5.9 Section II Titled Procedure P, page 2, (effective 9/4/12) Interviews: 1. Grievance coordinator 2. Random residents Findings (by Provision): 115.352 (a-g): In the PAQ, the agency stated that they do not have an administrative procedure for dealing with resident grievances regarding sexual abuse. All allegations of sexual abuse are called in to the hotline. All staff are mandatory reporters of sexual abuse to the hotline. The auditor reviewed Agency policy 5.9 Youth Grievance policy Section II Titled procedures P page 2, that outlines that all allegations of child abuse will conform to the State of Delaware's Mandatory reporting requirements and are not subject to the grievance procedures. Child Abuse Hotline (800)-292-9582. A review of the Stevenson House Detention Center Resident Handbook page 6 describes the grievance process and procedure for filing a complaint. The grievance process does not outline a procedure for completing an emergency PREA grievance. The auditor was able to review a copy of the Stevenson House grievance form and there was no information presented on the grievance form that indicated that the form was used for PREA. During interview, the Grievance staff stated they used to have an emergency PREA grievance form, but they have stream lined the process and now they just use the regular grievance form. If a resident wants to make a complaint, he would take them to call the PREA hotline and let the investigation team do their job. PREA complaints are handled immediately. The residents can take the complaint to someone they trust or any staff person. The evidence shows that the agency does not have an administrative procedure for processing grievances regarding sexual abuse this was verified by policy, interviews with Grievance coordinator, and resident handbook. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1, Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV E page 9, (Revised 6/29/17). 2. Title 10 Courts and Judicial Procedure 3. Memorandum of Agreement Between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (3/11/19). 4. Division of Youth Rehabilitative Services State Managed Facilities Mail, Telephone and Visitation Policy 5.24 (Effective 6/1/15). 5. Stevenson House Detention Center Resident's Handbook (revised June 2017) Interviews: 1. Resident 2. Superintendent 3. PREA compliance manager 4. Survivors of Abuse in Recovery (SOARS) Director Site Review Observation: 1. Observation during on-site review of physical plant Findings (by Provision): 115.353 (a): In the PAQ, the agency reported that they provide residents with access to outside victim advocates for emotional support services related to sexual abuse including making available addresses, telephone numbers including toll free hotline numbers for state, local, or national victim advocacy or rape crisis organizations. The facility provides residents access for reasonable communication to these organizations in as confidential manner as possible. The agency reported they do not provide information for immigrant services because they prohibit detention of persons for civil immigration purposes. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV E page 9, outlines that all youth shall be made aware of community agencies, address and contact numbers of mental health practitioners that provide emotional support services related to sexual abuse. The policy states that the agency will enter into a memorandum of agreement with one or more such agencies to ensure statewide service agreement but does not identify the agency by name. Neither the PAQ nor the policy provided any documentation for enabling reasonable communication to these organizations in as confidential manner as possible. The agency relies on Title 10 courts and judicial procedure 1007 that outlines that the facility does not detain residents for immigration purposes. During the site review, the auditors did not observe any postings for victim advocacy or rape crisis organizations in the housing units, library, classrooms, food service, visiting area, or lobby. During interviews with 16 residents, none of residents knew about the agency's outside victim advocates for emotional support services and could not provide the name of the agency, none of the sixteen residents knew about or how to receive the mailing addresses or phone numbers for contacting SOARS, a victim advocate or rape crisis organizations and was unaware of a toll free number for the outside victim advocacy agency SOARS, none of the sixteen residents knew about communicating to this organization confidentially. Prior to the onsite audit, the auditor tested the SOARS telephone number at (302)-655-3953 and was taken through a series of prompts to leave a message. Post audit the auditors were able to speak with SOARS Executive Director regarding their contact and services with the facility. Staff at SOARS confirmed that they have a memorandum of agreement with the facility to provide victim advocate for emotional support but have not had any contact with any residents at the facility. When asked how does a resident contact your agency, the SOARS staff stated they would call (302)-655-3953 and after the prompts select extension 1 for the intake department. The evidence shows that the agency has a policy that establishes that residents will be provided access to outside victim advocates for emotional support services related to sexual abuse and make available agency contact information. As written the policy does not provide any information about the confidentiality between residents and outside victim advocates. The auditor did not observe any information that would provide residents with the victim advocate for emotional support.

Residents interviewed could not provide the auditor any information about SOARS including their telephone number, mailing address or the level of confidentiality of communication between the agency and resident. The Stevenson House Detention Center resident's handbook did not provide any information to the residents about SOARS or any other outside victim advocate for emotional support related to sexual abuse. The agency does not provide information for immigrant services because the court places a child in secure detention pending adjudication but not for civil immigration purposes.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.353 (b):

In the PAQ, the facility reported that they inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. The facility reported prior to giving them access to outside support services, the facility would inform residents of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law

During interviews with residents, five out of 16 residents stated they were informed that conversations with outside support services would be monitored or the mandatory reporting rules, confidentiality that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality.

The evidence shows that not all residents interviewed were informed of the communication monitoring with SOARS or mandatory reporting limits to confidentiality with outside support services.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.353 (c):

In the PAQ, the facility reported that they maintain memorandum of understanding or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse.

The agency provided a copy of the Memorandum of agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc (SOARS). The Memorandum of agreement outlines that SOARS will provide victims of sexual abuse direct mental health services including crisis intervention, emotional support, information or referrals.

The evidence shows that the agency and SOARS has entered into a memorandum of agreement on 3/11/19 that outlines SOARS will provide victims of sexual abuse direct mental health services including crisis intervention, emotional support, information or referrals.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.353 (d):

In the PAQ, the facility reported they provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

The facility relies on Policy 5.24 Mail, Telephone and Visitation outlines that residents can contact their attorney at any reasonable time excluding weekends and holidays. The policy also outlines that attorneys, clergy, government officials, legislators and family may be approved for visitation by the superintendent.

During interviews, the superintendent stated the facility provides residents access to their attorney and family through Phone calls, mail, facetime and due to COVID there are no in-person visits. During interview, the PREA compliance manager stated they have telephone access and residents can write their attorney. The facility provides facetime with family and residents.

During interviews with residents, all 16 residents knew that they could make a private call to their attorney, all 16 residents knew that they could contact their families through facetime.

The evidence shows that agency policy provides that residents can make confidential calls to their attorney and have contact with a parent through phone calls and facetime visits. Facility staff stated that residents are allowed access to their attorney and parents through phone calls and facetime visits. The residents knew that they were allowed access to contact their attorney privately and visit with their parents through a facetime call.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Corrective Action:

1. Revise PREA Policy 2.13 Section IV, E, 2 to include that reasonable access for communication between residents to these organizations in as confidential manner as possible.
2. Train staff on the revised policy.

3. Document staff have received the training.
4. Educate all residents on the services provided by Survivors of Abuse in Recovery (SOARS) victim advocate for emotional support related to sexual abuse, contact information for the agency telephone, mailing address and inform residents of the mandatory reporting and limits to confidentiality.
5. Provide posting or otherwise making victim advocate for emotional support available to residents that would include mailing addresses, phone numbers for rape crisis and victim advocate organizations.
6. Document that all residents have received the education on SOARS.

Best Practice Recommendations:

1. Provide a mailing address on posting for Survivors of Abuse in Recovery (SOARS).
2. Revise Stevenson House Detention Center resident's handbook to include information on victim advocate for emotional support related to sexual abuse including reasonable communication between residents and agency in as confidential manner as possible.
3. Update the Stevenson House Detention Center resident's handbook on the website to the current version of June 2017.
4. Provide SOARS information at intake and during comprehensive education for residents.
5. Reestablish the communication between the agency and SOARS as outlined in the memorandum of agreement.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 6/1/21, 7/15/21 and 7/16/21 in response to the corrective action recommendations.

1. Provided revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21). (11 pages).
2. Revised PREA Policy 2.13 Staff Training Roster (8 pages).
3. Revised PREA Policy 2.13 Staff Training Roster (2 pages.
4. Resident SOAR Training Roster (2 pages).
5. SOAR Education Brochure (1 page).
6. SOAR Education Brochure Posting in Facility (3 pages).

The following action were taken: DYRS revised their PREA policy 2.13 on 5/13/21 to reflect all youth shall be made aware of community agencies, addresses and contact numbers of victim advocated that provide emotional support services related to sexual abuse. The Division shall maintain a Memorandum of Agreement with one or more such agencies to ensure statewide service agreement. Communication between residents and these agencies will be in as confidential manner as possible. Residents will be informed the extent their communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Corrective Action #1 through #6

The intent of this corrective action was to ensure that residents have reasonable access to outside victim advocate organizations and communication between residents to these organizations is in a confidential manner as possible and be informed the extent their communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The facility provided 10-page training roster that included 65 staff signatures acknowledging that they were trained on the agency's revised PREA policy 2.13. This satisfies the auditor's corrective action requirement.

The facility provided two-page training roster that included 19 resident signatures acknowledging they were trained about the SOARS outside victim advocate on 5/19/21. On June 1, 2021, the facility provided three pictures that show the posting of the SOAR brochure in the facility. The posting includes the location, mailing addresses and phone numbers for the victim advocate organization.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, C-1 page 5 (Revised 6/29/17). Child Abuse Reporting Line (800-292-9582) 2. Department of Services for Children, Youth and Their Families (DSCYF) Stevenson House Detention Center Public Website (http://kids.delaware.gov/yrs/prea). 3. Pre-Audit Questionnaire (PAQ) Findings (by Provision): 115.354 (a): In the PAQ, the facility indicated that they provide a method to receive third party reports of sexual abuse or sexual harassment. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, C-1 page 5 establishes that the Child Abuse hotline (800-292-9582) may be used by staff to report sexual abuse and sexual harassment. The agency establishes a method to receive third party reports publicly through the agency's website http://kids.delaware.gov/yrs/prea). The website provides a quick link for PREA that provides a method of receiving third party reports of sexual abuse or sexual harassment by calling the Delaware Child Abuse hotline (800-292-9582) or contacting a local law enforcement agency. The website also provides information on applicable PREA statutes and policies, contact information for the agency PREA coordinator, facility PREA compliance manager, Survivors of Abuse and Recovery, Inc. (SOARS) a victim advocate agency, and facility PREA audit reports. The evidence shows the agency and facility provide a method of receiving third-party reports of resident sexual abuse or sexual harassment. This information was verified through review of the agency policy and website information. Based on the review of the policy and agency website, staff and the public can make a third-party report of sexual abuse or sexual harassment by calling the child abuse hotline, reporting to a local law enforcement agency, contacting the agency PREA coordinator or facility PREA compliance manager. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations: 1. Revise the PREA Policy 2.13, Section C, (2-d), to include "Third party reporting" of sexual abuse or sexual harassment can be made by calling the Child Abuse Hotline at (800-292-9582).

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Division of Youth Rehabilitative Services Code of Ethics Policy 2.2 (Revised 3/5/19). 3. Pre-Audit Questionnaire (PAQ) Interviews: 1. Superintendent 2. PREA compliance manager 3. Medical and mental health staff 4. Random staff Findings (by Provision): 115.361 (a): In the PAQ, the agency reported they require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency relies on Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C.1, a, that outlines all staff are required to report any allegations and instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to the Child Abuse Hotline (800)-292-9582. In the PAQ, the agency reported they require all staff to report immediately any retaliation against residents or staff who reported such an incident. The agency relies on Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C.2,f, that outlines retaliation from youth or staff will result in disciplinary action and subject to the full progression of sanctions and or referral for criminal prosecution. As written, the policy does not require all staff to immediately report any retaliation against resident or staff who reported sexual abuse or sexual harassment. The policy outlines rather what are the sanctions of retaliating against a resident or staff. The agency relies on Policy 2.2 Division of Youth Rehabilitative Services Code of Ethics Section IV.A, 21, which outlines that each employee must report without reservation any corrupt or unethical behavior which could affect either a juvenile or the integrity of the organization. As written, the policy does not require all staff to immediately report any retaliation against resident or staff who reported sexual abuse or sexual harassment. In the PAQ, the agency reported they require all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency relies on Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C.2,d, that outlines that each facility will develop procedures for how staff can report sexual abuse, harassment and staff neglect or violation of responsibilities that may have contributed to any of these incidents. As written, the policy refers to developing procedures for reporting and does not specifically require all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency relies on Policy 2.2 Division of Youth Rehabilitative Services Code of Ethics Section IV.A, 21 outlines that each employee must report without reservation any corrupt or unethical behavior which could affect either a juvenile or the integrity of the organization. As written, the policy does not require all staff to immediately report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. During interviews, all Random staff reported that the agency requires them to report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility including retaliation against residents or staff that reported an incident and any staff neglect or violations of responsibilities that may have contributed to the incident of retaliation. During interviews all staff knew the agency's policy or procedure for reporting information related to a resident sexual abuse incident. Evidence shows that all staff are required to report regarding an incident of sexual abuse or sexual harassment. As written, the PREA Policy 2.13 and Code of Ethics Policy 2,2 does not require all staff to immediately report any retaliation against

resident or staff who reported sexual abuse or sexual harassment as required by this provision. As written, the PREA Policy 2.13 refers to developing procedures for reporting and does not specifically require all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. In addition, Code of Ethics Policy 2,2 does not specifically require all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Interviews with staff revealed they know about the agency's requirement to report and the policy and procedure for reporting information related to sexual abuse incident.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.361 (b):

In the PAQ, the agency reported that they require all staff to comply with any applicable mandatory child abuse reporting laws.

The agency relies upon Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C.1 a, titled mandatory reporting, that outlines all staff are required to report any allegations and instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to the child abuse hotline (800)-292-9582.

During interviews, all Random staff interviewed knew they were required to comply with mandatory reporting of sexual abuse and noted they would call the hotline.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.361 (c):

In the PAQ, the agency reported that policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Agency relies on Policy 2.2 Division of Youth Rehabilitative Services Code of Ethics Section IV.A,23 that outlines employees must maintain the integrity of confidential information. Employees will not seek personal data or reveal case information to anyone beyond what is needed to perform their job responsibilities. As written, the policy does not prohibit staff from revealing any information related to a sexual abuse report.

During interviews eight out of 13 staff knew the agency's policy or procedure for reporting information related to a resident sexual abuse incident.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.361 (d):

Medical and mental health staff when asked about a requirement to report sexual abuse to officials as well as state and local agencies medical and mental health staff stated they are mandated reporters and would report to their supervisors. When medical and mental health staff were asked at the initiation of services to a resident, do you disclose the limitations of confidentiality and your duty to report,, medical provider stated that they do disclose the limitations and their duty to report as they are mandated reporters. The mental health staff also stated that they would tell the resident what the limits of confidentiality and duty to report. Medical and mental health staff stated they are mandated by state code.

The auditor reviewed 11 resident files and 15 intake assessment reports but was not able to confirm that residents were informed of medical and mental health limits on confidentiality or duty to report.

Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required.

115.361 (e):

When asked when you receive an allegation of sexual abuse to whom do you report the allegation? The superintendent stated he would immediately report to the director. When asked would you report to the juvenile court if they retain jurisdiction or the juvenile's attorney the superintendent stated it would be reported to the hotline and the parents and or guardian.

When asked when you receive an allegation of sexual abuse to whom do you report the allegation, The PREA compliance manager (PCM) stated he would report it to the superintendent and the hotline. When asked if the victim is under the guardianship of the child welfare system, who would you report the allegation, to the superintendent and the hotline. When asked would you report the allegation to the juvenile's attorney if the court retains jurisdiction, the PCM stated this would be up to the director and the caseworker.

The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment

reported to the department.

Based upon this analysis, the facility is substantially compliant with this provision and a corrective action is not required.

115.361 (f):

When asked are all allegations of sexual abuse and sexual harassment including those from third-party and anonymous reported directly to designated facility investigators, the superintendent stated we report to the hotline and it would be determined by the child abuse hotline.

The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department

Based upon this analysis, the facility is substantially compliant with this provision and a corrective action is not required.

Based upon this analysis, the facility is not substantially compliant with this standard and a corrective action is required.

Corrective Action:

1. Revise PREA Policy 2.13 and Code of Ethics Policy 2.2 to require all staff to immediately report any retaliation against resident or staff who reported sexual abuse or sexual harassment.
2. Revise PREA Policy 2.13 and Code of Ethics Policy 2.2 to require all staff to report immediately and according to agency policy report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
3. Train staff on the revised policy.
4. Document staff have received training on revised policy.

Best Practice recommendations:

1. Revise Policy 2.2 Code of Ethics Section IV A, 23, to include that it prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 7/16/21 in response to the corrective action recommendations.

1. Provided revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21). (11 pages).
2. Provided revised Policy 2.2 Code of Ethics (revised 5/13/21). (3 pages).
3. Revised PREA Policy 2.13 Staff Training Roster (8 pages).
4. Revised PREA Policy 2.13 Staff Training Roster (2 pages.
5. Revised Code of Ethics Policy 2.2 Staff Training Roster (6 pages).

The following action were taken: DYRS revised their PREA policy 2.13 on 5/13/21 to reflect that staff will immediately report, to facility administration, any retaliation against a resident or staff who reported sexual abuse or sexual harassment and staff will immediately report any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation.

Corrective Action #1 through #4

The intent of this corrective action was to ensure that staff would immediately report retaliation against a resident or staff that reported sexual abuse or sexual harassment and violations of staff responsibility that may have contributed to an incident of retaliation. The agency provided an eleven-page revised PREA policy 2.13. The PREA policy outlines that staff will immediately report, to facility administration, any retaliation against a resident or staff who reported sexual abuse or sexual harassment and staff will immediately report any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. The facility provided 10-page training roster that included 65 staff signatures acknowledging that they were trained on the agency's revised PREA policy 2.13. This satisfies the auditor's corrective action requirement.

The agency provided a three-page revised Code of Ethic policy 2.2. The Code of Ethic policy outlines that staff will immediately report any retaliation against resident or staff who reported sexual abuse or sexual harassment. Staff will immediately report any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation. The facility provided 6-page training roster that included 67 staff signatures acknowledging that they were trained on the agency's revised Code of Ethics policy 2.2 This satisfies the auditor's corrective action requirement.

	Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV C.2, e titled Reporting, (page 6), (Revised 6/29/17). 2. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency head 2. Superintendent 3. Random staff Findings (by Provision): 115.362 (a) 1-4: In the PAQ, the facility reported that when they learn that a resident is subject to a substantial risk of imminent sexual abuse, they take immediate action to protect the resident assess and implement appropriate protective measures without unreasonable delay. The agency relies on Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C.2, e, titled Reporting, (page 6), that outlines that if a youth fears for his or her safety in their current setting they can request a temporary transfer to another location, another housing unit or cluster. This type of request can be made through facility procedures. As written, the policy does not specifically outline “substantial risk of imminent sexual abuse”. The facility does take action to protect residents from sexual abuse through the coordinated response plan, 90-day retaliation monitoring, transferring a resident to another housing unit. During Interviews, the agency head stated that she expects Remove the resident from the situation, the building, and provide protective observation During an interview, the superintendent stated they have a two-prong system in which they would first separate the resident by changing the housing unit and contact the director’s office. During interviews with random staff, the auditor learned that staff would remove a resident immediately if the resident was at risk of imminent sexual abuse. All staff interviewed reported they would separate the victim from the abuser to remove the resident from the situation and notify a supervisor if the resident was at risk of imminent sexual abuse. In the PAQ, the facility reported that for the past 12 months there was no residents determined to be at substantial risk of imminent sexual abuse. The facility reported that the average amount of time and longest time that passed before taking action was not applicable as there were no residents determined to be at substantial risk of imminent sexual abuse. The investigation documents reviewed was incomplete and lacked a full investigation report. The facility investigative files did not reveal an allegation of sexual abuse. The auditor did not have any additional information provided. The evidence shows that the agency reported that since there were no residents at substantial risk of imminent sexual abuse that the facility would have responded with immediate action to protect the resident and that the average and longest length of time was not applicable for this reason. As written, the agency policy does not address risk of imminent sexual abuse of residents but provided actions the resident could take in fear of their safety. The facility takes other actions to protect residents from sexual abuse through the coordinated response plan, 90 day retaliation monitoring, transferring a resident to another facility location or housing unit The reported that they did not have an allegation of sexual abuse during the 12 months preceding the onsite audit. Interviews with staff revealed that staff would take immediate action and remove a resident from risk of imminent sexual abuse. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations: 1. Although a policy is not required, the PREA policy does not specifically outline substantial risk of imminent sexual abuse”. Revise the Policy 2.13 PREA Section IV C.2, e, to specifically outline the actions the facility would take when they learn that a resident is subject to a “substantial risk of imminent sexual abuse”. 2. Train staff on the revised plan. 3. Document staff training.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, C 3 and D 1,b (Revised 6/29/17). 2. Pre-Audit Questionnaire (PAQ) Interviews: 1. Agency head 2. Superintendent Findings (by Provision): 115.363 (a): In the PAQ, the facility reported they have a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, C 3 and D 1, b, that states upon receiving an allegation that a youth was sexually abused while confined to another facility, the administrator of the facility that received the allegation shall notify the administrator of the facility or appropriate office of the agency where the alleged abuse occurred and shall notify the appropriate investigative agency. In addition, all matters that involve the allegation of sexual contact as defined in this policy will be reported to the Child Abuse Hotline. In the PAQ, the agency reported that there have been no allegations received by the facility that a resident was abused while confined at another facility that would prompt a facility response. The evidence shows that the agency has a policy that outlines the actions to be taken by the facility administrator upon receiving an allegation that a resident was sexually abused while confined at another facility including notifying the head of the facility and investigative agency. A review of the PAQ reveals that the facility received no allegations that a resident was abused at another facility and no further information was provided. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.363 (b): In the PAQ, the facility reported that their policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, C 3, a, that states such notification shall be provided as soon as possible but no later than 72 hours from receiving the allegation. The evidence shows that the agency policy outlines that notification would occur within 72 hours after receiving an allegation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.363 (c): In the PAQ, the facility reported that the facility documents that it has provided such notification within 72 hours of receiving the allegation. The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, C 3, b, that states the facility administrator shall document that notification to both the other agency administrator and the investigative agency has been made. Documentation must also show that YRS director and the Division's PREA coordinator have been notified. The facility reported that they have not received any allegations of sexual abuse during the last 12 months. The evidence shows that the facility has not received any allegations to provide notification that would prompt the facility to

document that notification within 72 hours. The policy outlines that documentation of the notification would occur within 72 hours of receiving the allegation consistent with this provision.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.363 (d):

In the PAQ, the facility reported that agency policy requires that allegations received from other agencies or facilities are investigated in accordance with the PREA standards. The facility reported in the last 12 months, they did not have any allegations of sexual abuse from other facilities.

The agency relies on Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV, D 1, b, that states all matters that involve the allegation of any sexual contact as defined in this policy will be reported to the Child Abuse Hotline.

During interviews, the Agency head stated the designated point of contact for the facility is the superintendent, for out of state we would notify the probation department and the PREA coordinator is always on call. During interviews, the superintendent stated that there have been no reports of another agency or the facility reporting an allegation.

The evidence shows that the agency policy does require that all allegations of sexual abuse are reported to the child abuse hotline for investigation. Information from the PAQ reveals the facility has not received any allegations of sexual abuse from another facility for investigation. No other information was provided to the auditor. Interviews with staff revealed that the superintendent would be the point of contact for allegations received from other agencies and the facility would report the allegation to the child abuse hotline.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Revise Policy 2.13 Section IV C 3, a, to provide how the facility documents notifications within 72 hours of receiving an allegation of sexual abuse and sexual harassment to other agencies.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Stevenson House Detention Center Coordinated Response 2. First Responder Checklist 3. DSCYF Academy Staff Training Interviews: 1. Random staff 2. Milford Police Department Findings (by Provision): 115.364 (a): In the PAQ, the agency reports that they have a first responder policy for allegations of sexual abuse, The agency relies upon the First Responder Checklist, Stevenson House Detention Center Coordinated Reponses Flowchart and the DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention as the outline for first responder actions to an allegation of sexual abuse. The Agency does not have a written first responder policy for allegations of sexual abuse. The First Responder Checklist outlines four steps to be taken upon learning of an allegation that a juvenile was sexually abused, the employee first responder shall be required to Step one- separate the alleged victim from abuser, Step two- preserve and protect any crime scene until appropriate steps can be taken to collect any evidence and contact the supervisor, Step three-request that the alleged victim not take any actions that could destroy physical evidence, including as appropriate washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating, Step four-ensure that the alleged abuser does not take any actions that could destroy physical evidence, including as appropriate washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating. The first responder checklist does not include the action of smoking for the alleged victim or alleged abuser as outlined in this provision. The Stevenson House Detention Center Coordinated Reponses Flowchart outlines four flowchart immediate responses. Staff sexual misconduct immediate response, Staff sexual misconduct investigation, Youth on Youth sexual assault immediate response, and Youth on Youth investigation. The Staff sexual misconduct states when a supervisor receives emergency grievance from a youth, they will remove the staff from the unit, take the youth to medical and mental health for evaluation, secure the location and contact the hotline and IA unit will screen allegation. The youth on youth sexual assault immediate response states when the line staff receive a report that a resident was sexually assaulted in the facility by another resident, staff will separate both youth (separate units) on one on one observation, request that the alleged victim not take any actions to destroy physical evidence washing, brushing teeth, changing clothes, urinating, drinking or eating but does not include smoking as outlined in this provision. In addition, the flowchart does not provide any action that the alleged abuser does not take that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. The DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention outlines that first responders are to separate the victim and perpetrator as quickly as possible, ask the victim and perpetrator to preserve evidence by not changing clothes, washing their face, body, teeth, hair, using the toilet, eat or drink, and secure the scene to control movement. The staff training does not specifically state urinating, defecating, smoking and brushing teeth as required in the provision. In the PAQ, the agency reported there was no sexual abuse allegation of a resident in the last 12 months. The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. Evidence shows that the agency does not have a first responder policy. The facility relies on the First Responder Checklist, Stevenson House Detention Center Coordinated Reponses Flowchart and the DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention as evidence to support first responder action for an allegation of sexual abuse. First Responder checklist, Stevenson House Detention Center Coordinated Reponses Flowchart and the DSCYF Academy staff training does not provide all the actions of a first responder. The First Responder Checklist does not include the action of smoking for the alleged victim or alleged abuser as outlined in this provision. The flowchart requests the victim

not to take any actions to destroy physical evidence washing, brushing teeth, changing clothes, urinating, drinking or eating but does not include smoking as required in this provision. Respectively, the flowchart does require the same actions for the alleged abuser. The staff training does not specifically state urinating, defecating, smoking and brushing teeth as required in the provision.

Based upon this analysis, the facility is not substantially compliant with this provision and corrective action is required.

115.364 (b):

In the PAQ, the agency reports their policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence.

The agency relies upon the DSCYF Academy staff training for prevention, detection outlines first responders are to separate the victim and perpetrator as quickly as possible, ask the victim and perpetrator to preserve evidence by not changing clothes, washing their face, body, teeth, hair, using the toilet, eat or drink, and secure the scene to control movement. The agency notes that any staff could be a first responder.

The agency's First Responder Checklist outlines the actions taken by a non-security first responder would be to request that the alleged victim not take any actions that could destroy physical evidence and then notify security employee.

In the PAQ, the agency reported that there was no sexual abuse allegation in the past 12 months made to a non-security first responder.

During interviews with random staff, the auditor learned that all random staff interviewed reported they would separate the victim from the abuser to remove the resident from the situation, four out of 13 random staff stated they would not allow the victim or perpetrator to shower or use the bathroom, and seven out of 13 would secure the crime scene.

Evidence shows that the agency does not have a first responder policy. The facility relies on the DSCYF Academy staff training for prevention, detection and response to sexual abuse in detention as evidence to support non-security first responder action for an allegation of sexual abuse. The agency's First Responder Checklist outlined the actions taken by a non-security first responder consistent with this provision. Based on the interviews with staff not all staff could consistently provide the actions they would take as a first responder.

Based upon this analysis, the facility is not substantially compliant with this standard and corrective action is required.

Corrective Action:

1. Revise the Coordinated Plan for Youth on Youth to request that the alleged abuser does not take any actions that could destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
2. Revise the Coordinated Plan to request that the alleged victim not take any action to include "defecating" and "smoking".
3. Revise the First Responder Checklist to include smoking for the alleged victim as outlined in the provision.
4. Revise the training to include urinating, defecating, smoking and brushing teeth as required by the provision.
5. Train staff on the revised Coordinated Plan, First Responder Checklist and training.
6. Document staff training.
7. Develop or Revise Policy 2.13 PREA to create a section to include the first responder and non-security first responder duties as required by this standard.
8. Train staff on the revised policy.
9. Document staff training.

Best Practice Recommendations:

1. Revise Coordinated Plan to state Staff Sexual "abuse", Youth on Youth Sexual "abuse" as outlined in the standard.
2. Train staff on the revised plan.
3. Document staff training.

Verification of Corrective Action since the audit:

The facility sent the auditor documentation on 5/13/21, 7/15/21, 7/16/21 in response to the corrective action recommendations.

1. Provided revised Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (Revised 5/13/21). (11 pages).
2. Revised PREA Policy 2.13 Staff Training Roster (8 pages).
3. Revised PREA Policy 2.13 Staff Training Roster (2 pages.

4. Coordinated Response Plan (7 pages).
5. Coordinated Response Training Roster (8 pages).

The following action were taken: The agency revised their PREA policy 2.13 on 5/13/21 to ensure that security staff first responders request that alleged victims do not take any action that would destroy physical evidence and to ensure that the alleged abuser does not take any actions that would destroy physical evidence. The agency revised the Coordinated response for Youth on Youth to request that the alleged victim and abuser does not take any actions that could destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. As a best practice, the agency revised the PREA policy 2.13 to include first responder duties.

Corrective Action #1 through #6

The intent of this corrective action was to ensure that security first responders knew what actions they should take to inform alleged victims and abusers in requesting and ensuring that physical evidence is not destroyed. The agency provided a seven-page revised coordinated response that requires the alleged victim and abuser not take any actions that could destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. The training roster provides that 64 staff was trained on the PREA facility Coordinated Response process on 4/5/21, 5/7/21, 5/24/21, 6/10/21, 6/17/21 and 7/6/21. The roster provided staff signatures that confirm their attendance for the training. This training satisfies the auditor's corrective action requirement.

Corrective Action #7, #8, #9

The intent of this corrective action was to ensure that the agency policy included the duties of the security first responder and non-security first responder as it relates to the coordinated facility response plan. The agency provided an eleven-page revised PREA policy 2.13. The PREA policy outlines that each facility will follow the coordinated facility response and utilize the first responder cards and the coordinated response flowcharts. The facility provided 10-page training roster that included 65 staff signatures acknowledging that they were trained on the agency's revised PREA policy 2.13. This satisfies the auditor's corrective action requirement.

Based on review of the information received, the auditor finds the facility substantially compliant with this standard.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Residential Cottages Immediate Response (Coordinated Response) Flowchart 2. First Responder Checklist Interviews: 1. Superintendent Findings (by Provision): 115.365 (a): In the PAQ, the facility reported they developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The facility has the Stevenson House Detention Center Immediate Response Flowchart and a First Responder Checklist as their written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. There are four flowcharts that outline immediate responses by staff. Staff sexual misconduct immediate response, Staff sexual misconduct investigation, Youth on youth sexual assault immediate response, and Youth on youth investigation. The Staff sexual misconduct states when a supervisor receives emergency grievance from a youth, they will remove the staff from the unit, take the youth to medical and mental health for evaluation, secure the location and contact the hotline and IA unit screens allegation. The plan further outlines that the supervisor will notify the superintendent, initiate a reportable event, prepare PREA documentation and notify deputy director. The staff sexual misconduct investigation outlines that after IA screens allegation if they accept IA or IA and Police will coordinate investigation. If IA does not accept the IA case is closed and the allegation is referred to the PREA compliance manager and PREA investigator to conduct an internal investigation. The youth on youth sexual assault immediate response states when the line staff receive a report that a resident was sexually assaulted in the facility by another resident, staff will separate both youth (separate units) on one on one observation, request that the alleged victim not take any actions to destroy physical evidence washing, brushing teeth, changing clothes, urinating, drinking or eating, The plan further outlines that the staff will notify a supervisor and supervisor will notify AOD on duty, take victim to medical unit to be transported to Bayhealth Hospital for exam, supervisor or medical will notify hotline for IA to screen allegation. The facility will offer victim services and reassessment of housing and safety concerns when victim returns. The staff sexual misconduct investigation outlines that after IA screens allegation if they accept, IA or IA and Police will coordinate investigation. If IA does not accept the IA case is closed and the allegation is referred to the PREA compliance manager & PREA investigator to conduct an internal investigation. The first responder checklist outlines the steps to be taken upon an allegation of sexual abuse by first responders. The checklist provides the first responder with a detailed list of questions to ask the resident and actions to be taken such as separating the youth from alleged abuser, preserve and protect the crime scene until evidence can be collected, contacting supervisor, request that the alleged victim and the alleged abuser not take any action that would destroy physical evidence such as washing, brushing teeth, changing clothes, urinating, defecating, drinking or eating, call for mobile escort to the medical unit for evaluation, notifications to hotline, medical services response, and post allegation responsibilities. During an interview, the superintendent stated if sexual abuse was reported to him the facility has a coordinated response and the Division of Family Services is contacted, director's office, video monitoring, we can determine if anything needs to be done, clinical team, medical health, administration to make sure the resident is safe. The evidence shows that the agency has a written institutional plan to coordinate a response to incidents of sexual abuse among staff first responders, medical and mental health, investigators and facility leadership which was verified through the Stevenson House Detention Center immediate response flowchart, first responder checklist, and interview with superintendent. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

	Best Practice Recommendation: 1. Revise the Coordinated plan for Youth on Youth to request that the alleged abuser does not take any actions that could destroy physical evidence including washing, brushing teeth, changing clothes, urinating, drinking or eating. 2. Train staff on the revised plan. 3. Document staff training.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services Policy 309 Removal of Employees from the Workplace Section II 5 Page 1 (revised 7/1/12). 2. Agency Website (Http://kids.delaware.gov/policies/dscyf/dsc309-removal-of-employees-from-workplace. (11/1/2012). Interviews: 1. Agency head 2. Union Representatives Findings (by Provision): 115.366 (a): In the PAQ, the agency reported they have not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Collective Bargaining Agreements remains the same, contract negotiations began in 2020 and remain pending. State of Delaware Department of Services for Children Youth and Their Families Division of Youth Rehabilitative Services Policy 309 Section II 5 Page 1, establishes the right to remove employees from the workplace when they pose a risk to the safety of residents for allegations of sexual abuse. An administrative investigation would be completed within seven days of a removal from the workplace and if findings indicate termination is warranted the employee may be suspended without pay pending termination. The staff will not be allowed to resign in lieu of termination. During an interview, when asked has the agency entered into or renewed any collective bargaining agreements or other agreements since August 20, 2012, the agency head reported that they have no and they go into negotiations this year. During an interview with union representative, staff stated they go into negotiations this year. When asked does your current agreement permit removal of an employee related to allegations of sexual abuse, staff affirmed that staff can be removed. The evidence shows that the agency has not entered into a collective bargaining agreement that limits the agency's ability to remove an employee from duty which is verified through the agency policy and interview with staff. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 Section IV C Titled Mandatory Reporting, 2-f Page 6 (Revised 6/29/17). 2. Stevenson House Detention Center Organizational Chart (Updated April 2020). Interviews: 1. Agency head 2. Superintendent 3. Designated Staff Member Charged with Monitoring Retaliation Findings (by Provision): 115.367 (a) 1-2: In the PAQ, the agency reported they have a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C, 2-f titled Mandatory Reporting Page 6, establishes that retaliation from youth or staff will result in disciplinary action and subject to full progression of sanctions and or referral for criminal prosecution. In the PAQ, the agency reported that they have designated the PREA Compliance Manager as the staff member that monitors for possible retaliation. A review of the Stevenson House Detention Center organizational chart confirms that the PREA Compliance Manager is a supervisor. The evidence shows that the agency has outlined a policy to protect residents and staff from retaliation and has designated a supervisory staff member to monitor for possible retaliation which was verified through the agency policy and organizational chart. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.367 (b): Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C, 2-f Page 6, titled Mandatory Reporting (page 6) establishes that for a youth who fears their safety, they can request a temporary transfer to another location, housing unit or cluster. Additional staff may be used if housing options are not available. Retaliation from youth or staff will result in disciplinary action and subject to the full progression of sanction and or referral for criminal prosecution. During an interview, the agency head stated she would remove the resident and the staff from the building, talk to them and find out where they feel safe. During an interview, the superintendent stated the PREA compliance manager who is responsible for retaliation monitoring would speak with the resident if the resident was having any issues. During an interview, the supervisor responsible for retaliation monitoring stated they would make sure all things in policy are meet, no retaliation is taking place, separate the resident, remove staff, and monitor for bullying. Staff indicated the resident would stay at the facility and they would monitor closely. The evidence shows that the agency has outlined that they employ multiple measures residents and staff that fear retaliation for reporting sexual abuse or sexual harassment. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.367 (c) 1-5: In the PAQ, the facility reported that they monitor the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for 90 days or longer if needed. The facility reported there has been no incidents of retaliation in the past 12 months. Although a policy is not required for this provision, the facility relies upon Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C, 2-f titled Reporting Page 6, that provides retaliation from youth or staff will result in disciplinary action and subject to full progression of sanctions and or referral for criminal prosecution. The policy does not outline that they would monitor the conduct of resident and staff who reported sexual abuse for possible retaliation for 90 days or longer if needed.

During interviews, the superintendent described the measures she would possibly take would be to determine if anything needs to be done and speak with the clinical team, Mental Health, Medical, administration to make sure the resident is safe. During an interview, the retaliation monitor described the actions he would take by initiating contact with the resident and monitoring the resident closely to ensure that staff is not around the resident.

The evidence shows that the agency has a policy to protect residents and staff from retaliation and has designated a supervisor to monitor retaliation of residents and staff which was verified through the agency policy, organizational chart, PREA retaliation monitoring form, interview with the agency head and staff supervisor for retaliation monitoring.
Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.367 (d):
The agency reported in the PAQ that there has not been an incident of retaliation in the past 12 months that would prompt monitoring a resident as required by this provision.
During interviews, the retaliation monitor described that they would look for in bullying, placement of the resident, any signs that make the resident feel uncomfortable when detecting retaliation of residents. Staff indicated they would initiate contact with the resident and monitoring the resident closely.
The evidence shows that the facility has a process to monitor retaliation for residents through the PREA Compliance Manager who is responsible for retaliation monitoring.
Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.367 (e):
Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV C, 2-f titled Mandatory Reporting Page 6, establishes that retaliation from youth or staff will result in disciplinary action and subject to full progression of sanctions and or referral for criminal prosecution.
During interviews, the agency head and superintendent outlined the measures to protect an individual from retaliation would be remove the resident and the staff from the building talk to them and find out where they feel safe. They would be to determine if anything needs to be done and speak with the clinical team, Mental Health, Medical, administration to make sure the resident is safe.The agency reported in the PAQ that there has not been an incident of retaliation in the past 12 months.

The evidence shows that the facility has a process to monitor retaliation for residents for 90 days or longer if needed which was verified through the PAQ, organizational chart interviews.
Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Revise the PREA Policy 2.13, Section IV C 2-f titled Mandatory Reporting, to include “all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations are protected from retaliation by other residents or staff”.
2. Revise the PREA Policy 2.13, Section IV C titled Reporting Section F, to include retaliation monitoring for 90 days or longer if needed”.
3. Train staff on the revised PREA policy.
4. Document that staff have received training on the revised PREA policy.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) 2.20 (Revised 3/5/19). 3. Stevenson House Detention Center Legal, Programmatic Rights Program Access SHDC-501 (2/7/03). Interviews: 1. Superintendent 2. Medical and mental health staff Site Review Observations: Site review of facility Findings (by Provision): 115.368 (a) 1-7: In the PAQ, the agency reported residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all resident's safe can be arranged. Policy 2.13 Division of Youth Rehabilitative Services (DYRS) Prisoner Rape Elimination Act, Section IV B, 2-3 titled Prevention (pp.3-4) establishes that classification or assessment tools will be utilized to determine supervision needs of youth for the protection of victims and those to be perpetrators. The form of protective supervision includes housing decisions, movement throughout the facility, all routine and non-routine activities. In the PAQ, the agency reported that they have a policy that requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large muscle exercise. Policy Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) 2.20 Section IV, Titled Special Considerations E, C, establishes that LGBTQI youth may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other youth safe, and then only until alternative means of keeping all youth safe can be arranged. During any period of isolation, DYRS staff shall not deny youth daily large-muscle exercise and any legally required educational programming or special education services. Youth in isolation shall receive daily visits from medical staff or behavioral health services clinician or provider. Youth shall also have access to other programs and work opportunities to the extent possible. Policy Stevenson House Detention Center Legal, Programmatic Rights Program Access SHDC-501, outlines that Youth have the right to both indoor and outdoor recreational opportunities and equipment. During an interview, when asked if there were any recent incidences in which a resident was isolated the superintendent stated there was no incidents of residents who allege to have suffered sexual abuse who were placed in isolation. If there was a need to separate it would only be until alterative arrangement could be made. During an interview with medical and mental health staff, staff indicated that when there is an administrative intervention, they would visit them twice a day in response to COVID 19. During the onsite review, the auditor went into the facility visiting room, library, maintenance area, food service, housing units, classrooms, central control, administration area, and did not observe any segregated housing units or isolation rooms. Stevenson House Detention Center had secure housing unit entrances, cells and exits. All areas require a key or remote access to enter. The evidence shows and the facility staff confirm that there were no residents isolated at the facility that alleged to have suffered sexual abuse. Staff reported that if there was a need to separate a resident, it would only be until an alternative arrangement could be made. The auditor's observation of the facility did not reveal any type of segregated housing or

	isolation room, cell or housing that would confirm that the facility isolates residents as outlined in this provision. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS 2.13IV.D.1.a-i 2. DYRS Policy 2.13.IV.D.4.c 3. Affirmation of Compliance with Investigative Standards for Sexual Assaults 4. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect 5. Investigative File 2018 6. Institutional Abuse Investigator Certificates-NIC PREA: Investigating Sexual Abuse in Confinement Settings 7. Facility PREA Investigator Certificate-The Delaware Department of Correction: PREA Investigations Training 8. Notification of Investigation Status Form 9. Sexual Abuse Review of Substantiated and Unsubstantiated Outcomes Form 10. Non-Critical Reportable Event Form Interviews: 1. Milford Police Department (MPD) 2. Institutional Abuse (IA) investigator 3. Facility PREA investigator 4. PREA coordinator 5. PREA compliance manager 6. Superintendent Site Review: 1. Management analyst office 12/15/2021 Findings (by Provision): 115.371 (a):-1 Within DYRS Policy 2.13, there is a section that addresses investigations in secure care. The policy details that all matters that involve the allegation of any sexual contact as in this policy will be reported to the Child Abuse Hotline. Further, the policy mentions that for matters which could result in a criminal action, Institutional Abuse will conduct a joint investigation with the Milford Police. For the purpose of training, DYRS Policy 2.13.IV.D.4.c requires when there are no allegations of sexual abuse or sexual harassment, the facility is required to complete a mock incident review annually. The auditors were provided two mock incident reviews. Due to the Stevenson House Detention Center not having any allegations of sexual harassment and sexual abuse within 12 months, the auditor decided to review the last investigative file from 2018. During an interview with MPD, it was disclosed that there were two sexual abuse allegations reported at the facility. One alleged to have occurred in the community and the other alleged to have occurred at a contracted residential facility. There was one sexual abuse investigative file for 2018 which was received through the PAQ. The investigative file was comprised of a non-critical reportable event form, a sexual violence incident form, sexual violence incident form for victim, sexual violence incident form for youth perpetrator, email-detailing the screening out by IA, and a copy of the Prison Rape Elimination Act: Notification of Investigation Status. The investigation was found to be unsubstantiated. The following items were missing from the investigation file: 1. Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes 2. Footage of Incident 3. Facility PREA Investigators Report 4. Victim Statement Based on the documentation received by the auditor, the report lacked necessary documents to be considered thorough. Being there was the lack of documentation with narratives, the auditor was unable to verify if the documentation was objective. Further, the incident occurred on 9/22/2018, but the grievance was not processed until 9/26/2018. This allegation was reported through the grievance process, and the facility has an Emergency PREA Grievance Process which should have identified this allegation earlier than 4 days. According to documentation, attempts at contacting the PREA hotline had failed twice, and an administrative call to the Child Abuse Hotline was made on 9/27/18. Lastly, the allegation was not screened out from IA until 10/10/18. The agency did not demonstrate efficiency in the 2-week delay to determine that the allegation did not

meet the threshold for an IA investigation, and the allegation was then screened out for investigation by the facility. For these reasons, the auditor has determined that the investigation was not handled promptly.

During interviews with IA investigators and the facility PREA investigator, it was confirmed that the agency conducts investigations for all allegations including third party and anonymous reports. The agency does not meet compliance in this provision.

115.371(b)-1

The facility has provided three investigator certificates through the PAQ. During the onsite audit, the auditors were provided the facility PREA investigators certificate. Two of the investigators have taken the NIC PREA: Investigating Sexual Abuse in Confinement Settings. One of the investigators took an additional training titled NCIC PREA Investigator: Sexual Abuse Investigations in Confinement Settings-Advanced. The facility PREA investigator took the Delaware Department of Correction: PREA Investigations Training in 2016. In the 2018 investigative file, the auditor was able to determine that the allegation was investigated by the facility PREA investigator.

Both the Facility PREA investigator and the IA investigator confirmed the completion of the specialized training in conducting sexual abuse investigations in confinement settings. The IA investigator confirmed training in techniques for interviewing, proper use of Miranda and Garrity warnings, sexual abuse evidence collection, and the criteria and evidence required to substantiate a case for administrative or prosecution referral. The facility PREA investigator admitted not recalling the subject matter of the training received. The agency does substantially meet compliance in this provision of providing training for investigators.

115.371(c)-1

Review of the sexual abuse investigative file from 2018, the allegation had been screened out by IA. Once the allegation was returned to the facility to investigate, the investigation was not processed any further. The auditor found no proof of the collection of direct and circumstantial evidence, and there was no available electronic monitoring. The original grievance that prompted in the investigation was not available in the investigative file. The alleged victim nor the alleged perpetrator were interviewed by the investigator. Based on the documentation contained in the file, there was no evidence of a consult to FOCUS for prior reports and complaints of sexual abuse involving the suspected perpetrator. The agency does not meet compliance in this provision.

115.371(d)-1

In the Affirmation of Compliance with Investigative Standards for Sexual Assault, it explicitly expresses that MPD will not terminate an investigation solely because the source of the allegation recants the allegation. In the 2018 sexual abuse investigative file the auditor could not determine if the allegation was recanted due to the investigative file lacking pertinent information. According to both the IA investigator, Facility PREA investigator, and MPD investigations do not terminate if the source of the allegation recants. The agency does substantially meet compliance in this provision.

115.371(e)-1

According to the IA investigator, there have been no sexual abuse investigations that rose to criminal threshold. Investigations that meet the criminal threshold are jointly investigated by MPD and IA. In the case of compelled interviews, MPD would be responsible for consulting with prosecutors prior to conducting a compelled interview. Interview with IA investigator confirmed the procedure for conducting compelled interviews. The agency does substantially meet compliance in this provision.

115.371(f)-1

When assessing the credibility of an alleged victim, witness, or suspect, the IA investigator stated that the credibility is based on an individual basis. It is not based on the individual's status as a resident or staff member. Further, it was confirmed from the IA investigator the agency does not require a youth that alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition to proceed with an investigation. During the onsite audit, there were no residents who had reported sexual abuse at the Stevenson House Detention Center to further confirm.The agency does substantially meet compliance in this provision.

115.371(g)-1

DYRS administrative investigation of the 2018 investigation file of sexual abuse, there is no statements of concern by the investigator regarding the practice of determining whether staff actions or failures to act contributed to the abuse. There was no reasoning behind credibility assessments nor investigative facts.

During the auditor's inquiry regarding documents contained in investigation files, the facility PREA investigator was unable to provide a detailed list of documentation included in an investigative file of sexual abuse or sexual harassment. The agency

does not meet compliance in this provision.

115.371(h)-1

DYRS has not reported or provided documentation of any criminal investigations during the onsite or via the PAQ. The auditor interviewed MPD, and the auditor was informed that criminal investigations would be documented in a report. The report would be distributed to the IA investigators. In turn, the IA investigators would provide that information to the facility superintendent and PREA compliance manager. During the interview with MPD, it was disclosed that there were 2 allegations of sexual abuse that was reported at Stevenson House Detention Center. These allegations were reported at the facility, but they allegedly occurred in the community and at a contracted residential facility. The agency does substantially meet compliance in this provision.

115.371(i)-1

Cited in DYRS Policy 2.13IV.D.1.g, acts deemed to be a criminal offense, as recognized by the Child Abuse Hotline, will be referred to the Milford Police Department. In both the interview with MPD and the IA investigator, the auditor determined that substantiated allegations of conduct that appear to be criminal are referred for prosecution. According to MPD, there were no substantiated allegations of conduct that appeared to be criminal that was referred for prosecution from the Stevenson House Detention Center within the last 12 months. The agency does substantially meet compliance in this provision.

115.371(j)-1

During the initial interview of the management analyst on 12/15/2020, there was a site review of the management analyst office. During the 2/15/2021 interview, there was an inquiry by the auditor if the practice of the two-lock system changed. The management analyst affirmed there had been no changes. The file cabinet contained past years of written reports of sexual harassment and sexual abuse. The management analyst disclosed that the files were maintained from the previous management analyst. In DYRS Policy 2.13.IV.F.6-7 is the agency's retention policy of no less than 10 years after the date of its initial collection unless, Federal, State, or local law requires otherwise. The agency does substantially meet compliance in this provision.

115.371(k)-1

According to interviews with both IA investigator and the facility PREA investigator, the departure of an alleged abuser or victim from employment or control of the facility or agency does not provide a basis for terminating an investigation. The agency does substantially meet compliance in this provision.

115.371(l)-1

The Affirmation of Compliance with Investigative Standards for Sexual Assaults ensures that MPD conducts investigations in accordance with 115.371(a)-(k). The agency does substantially meet compliance in this provision.

115.371(m)

MPD stated during the interview that IA jointly with MPD will conduct investigations, and MPD will provide reports and inform IA of the process of investigations. The auditor confirmed through interviews with the superintendent and the PREA compliance manager that MPD would provide information pertaining to a sexual abuse investigation at the Stevenson House Detention Center to IA. The agency does substantially meet compliance in this provision.

The evidence provided shows that the agency has a policy related to criminal and administrative agency investigations. Review of the sexual abuse investigative file in 2018, showed there was not sufficient information provided such as interviews, direct or circumstantial evidence, video footage, or review of prior reports and complaints of alleged perpetrator. Interviews of investigators have confirmed that investigations are not terminated due to the source of the allegation recants and credibility is assessed on an individual basis. Additionally, investigations are not terminated due to the departure of an alleged abuser or victim from employment or release from the facility. Based on the sexual abuse investigative file of 2018, the facility does not report if staff actions or failures contributed to the abuse, and the investigations lack the description of physical evidence, testimonial evidence, credibility assessment, and investigative facts. The site review confirmed the practice of maintaining written reports in accordance to 115.371(j), but the DYRS Policy 2.13 needs to be revised to the provision. MPD and IA have both confirmed investigations of sexual abuse and sexual harassment are conducted jointly, and information would be shared with IA of the progress of the investigation.

Based on this analysis, the Stevenson House Detention Center does not meet the standard. Corrective action is required.

Corrective Action:

1. In accordance with DYRS Policy, train two facility PREA investigators on Conducting Sexual Abuse Investigations in Confinement Setting.

2. Revise Policy 2.13.IV.F.6-7 in accordance to PREA Standard 115.371(j).

Best Practice Recommendations:

1. DYRS 2.13.IV.D.1 remove the reference to DYRS policy on Reporting Crimes in State Facilities. Replace with information from the actual policy on Reporting Crimes in State Facilities.
2. Document when the Child Abuse Hotline or the IA investigators screen out allegations of sexual harassment and sexual abuse to be investigated administratively by the facility PREA investigators.
3. Collaborate with the management analyst, facility administration, and the facility PREA investigators to develop a coordinated plan for uniformity in obtaining and retaining documentation of investigations.

Verification of corrective action since the audit-

In response to the corrective actions, the facility provided documentation to the auditor through the supplemental files of the OAS. For both corrective action #1 and corrective action #2, the PREA coordinator provided a copy of the revised PREA policy 2.13 which was uploaded to OAS and published on the agency website on 5/13/2021.

The following actions were taken by the facility for corrective action #1: the PREA coordinator provided the revised PREA Policy 2.13 which did not require 2 PREA investigators at the facility. The auditor initially cited the facility for not adhering to their established policy. The PREA standards do not require a specific number of investigators, but it is recommended that the facilities practice having facility level PREA investigators readily available. Within the revised PREA Policy 2.13.IV.C.3.a, it states that PREA investigators are required to complete specialized training in conducting investigations in confinement settings. This training will include training pertaining to the techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, how to collect evidence after sexual abuse incidents and what criteria and evidence are needed to substantiate a case. On 8/2/2021, the PREA coordinator provided a PREA investigative file dated 4/22/2021 which demonstrated improvement in the investigative practices and documentation and evidence needed to substantiate an investigation of sexual harassment.

The following actions were taken by the facility for corrective action #2: the agency provided a revision to PREA Policy 2.13.IV.J.9-10 which states All PREA data shall be securely stored by the Management Analyst using a double lock system. PREA data shall be retained for no less than 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. Additionally, the facility provided documentation that all staff were trained on the revisions to the policy.

Corrective Action #1

The intent of the corrective action was to ensure compliance to PREA policies created by the agency as well as ensuring that the policy cites the training required of PREA investigators. The agency revised PREA policy 2.13 requires that PREA investigators receive specialized training in investigating sexual abuse and sexual harassment in confinement in accordance with PREA standard 115.371(c).

Corrective Action #2

The intent of the corrective action was to ensure that all PREA data is securely stored and retained.

Based on the information provided to date, the facility is substantially compliant with the standard.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DSCYF Policy 208 2. State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol p.98 Interviews: 1. IA investigator Findings (by Provision): 115.372 (a)-1: DSCYF Policy 208 was provided in the PAQ to address PREA Standard 115.372(a). The policy makes references to investigating utilizing DFS Institutional Abuse Investigation Protocol policy and procedures. The policy does not have language specific to determining the standard evidence utilized in sexual harassment and sexual abuse investigations. PREA mandates require imposing a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. Written in the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol, DFS (IA) will make a finding once it has established that a preponderance of the evidence exists. Review of the sexual abuse investigative file of 2018, the file lacked documentation for the auditor to determine whether the agency imposed a standard of the preponderance of the evidence or a lower standard of proof. The investigation was completed by the facility PREA investigator. It was disclosed by the IA investigator that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The agency does substantially meet compliance in this provision. Based on the analysis of the State of Delaware Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect: Child Abuse Protocol, the interview with the IA investigator, the auditor has determined that DYRS does not impose a standard higher than a preponderance of the evidence when determining if allegations of sexual abuse or sexual harassment are substantiated. The agency is substantially compliant with this standard and no corrective action is needed at this time.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.D.1.i 2. DYRS Policy 2.13 Attachment E Notification of Investigations Status 3. Sexual Abuse Investigation 2018 Interviews: 1. Facility PREA investigator 2. Superintendent 3. PREA compliance manager 4. Superintendent 5. Milford Police Department (MPD) 6. Random residents Findings (by Provision): 115.373 (a)-1-3: DYRS Policy 2.13.IV.D.1.i pertains to informing residents who make allegations that they have suffered sexual abuse in an agency facility verbally, or in writing that the allegations have been determined to be substantiated, unsubstantiated, or unfounded. The policy specifically states that upon notification from Institutional Abuse or Law Enforcement, the program administrator will ensure that the youth is notified of the outcome of the case via the Notification Form. The auditor reviewed a sexual abuse investigative file from 2018 to check for compliance since there were no sexual abuse investigations in the prior two years of this audit. During 2018, there was one sexual abuse investigation. It was resident on resident, and it was an administrative investigation. Based on the sexual abuse investigative file, there was a notification form completed and signed by both the DYRS program administrator. The concern of the auditor was the date the form was initiated was prior to the date contacted by IA of the screening out of the allegation. The practice of notification of outcomes to residents alleging sexual abuse was further confirmed by the facility PREA investigator, and the superintendent. The agency does substantially meet compliance in this provision. 115.373 (b)-1: In the last 12 months, there were no sexual abuse cases that were referred for criminal investigation documented in the PAQ. This was further collaborated with interviews with MPD, the PREA compliance manager, and the superintendent. The agency does substantially meet compliance in this provision. 115.373 (c)-1-3 Within the last 12 months, there were no sexual abuse cases that were either substantiated, unsubstantiated, or unfounded committed by a staff member against a resident at the Stevenson House Detention Center. Additionally, there were no residents that reported a sexual abuse during the onsite audit. The agency does substantially meet compliance in this provision. 115.373 (d)-1 Within the last 12 months, there were no sexual abuse cases that were alleged by a resident by another resident. Further confirmed by interviews with random residents. The agency does substantially meet compliance in this provision. 115.373 (e)-1-3 DYRS Policy 2.13 specifically states that upon notification from Institutional Abuse or Law Enforcement, the program administrator will ensure that the youth is notified of the outcome of the case via the Notification Form. Within the last 12 months, there were no residents that were sexually abused. The agency does substantially meet compliance in this provision. The evidence shows that the agency has a policy that provides residents who have alleged sexual abuse in an agency facility with written notification utilizing the Notification of Investigation Status Form. The auditor corroborated this practice from the sexual abuse investigation file in 2018. There were no sexual abuse investigations within the last 12 months.

	Based on the analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations: 1. Add language to DYRS Policy 2.13 in accordance to PREA Standard 115.373(c-d)

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect (Revised 12/15/16). 3. Removal of Employees from the Workplace Policy 309 (Revised 11/1/12) 4. Delaware Department of Human Resources Policy on Sexual Harassment Prevention (Revised October 2005). 5. Delaware Children's Department Policy 208 Institutional Abuse (Revised 6/8/16). Findings (by Provision): 115.376 (a): In the PAQ, the facility states staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on Policy 2.13 Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) Section IV C, 1, a, and C 2, f, outline that all staff are required to report any allegations and instances of non-consensual sexual acts, abusive sexual contact, and sexual harassment to the Child Abuse Hotline (800)-292-9582. In addition, retaliation from staff will result in disciplinary action and be subject to full progression of sanctions and or referral for criminal prosecution. As written, the policy refers to staff mandatory reporting of sexual abuse and sexual harassment allegations and retaliation by staff. The policy does not state that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect, that outlines if as a result of a prohibited offense, ineligible determination or a substantiation of child abuse or neglect a recommendation for termination is warranted. As written, the policy does not mention sexual abuse or sexual harassment and does not state that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on Policy 309 Removal of Employees from the Workplace, that outlines that allegations of events that may lead to immediate removal from the workplace include but not be limited to physical or sexual abuse against a resident. The policy refers to allegations of sexual abuse and does not specifically outline that staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility relies on DHR policy on sexual harassment prevention, that outlines that employees are strictly prohibited from engaging in any form of sexual harassment from an employee from any state facility to another employee. As written, this policy refers to employee on employee sexual harassment and not residents. The policy does not specifically state staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies. The facility reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The evidence shows that the policies provided do not specifically state staff is subject to disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies, there was no staff during the last 12 months disciplined or terminated for violating the agency sexual abuse and sexual harassment policies. Based upon this analysis, the facility is substantially compliant with this provision and corrective action is not required. 115.376 (b): In the PAQ, the facility reported in the last 12 months there was no staff at the facility that violated, resigned or have been terminated for violating the agency sexual abuse or sexual harassment policies. Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.376 (c):

In the PAQ, the facility reported that sanctions for violations of agency policies relating to sexual abuse or sexual harassment are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The facility reported the last 12 months there had been no staff disciplined for violating the agency's sexual abuse or sexual harassment policy.

The facility relies on PREA Policy 2.13 Section IV, e-f, that outlines that for all incidents that occur in agency operated facilities, the agency will pursue personnel actional that honor due process and decision making that is in the best interest of the child and upon completion of an investigation, the facility administrator will make a recommendation for training and or discipline after consulting with the human resource unit.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.376 (d):

In the PAQ, the facility reported all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The facility reported the last 12 months there had been no staff terminations or resignations for violating the agency's sexual abuse or sexual harassment policy.

The facility relies on Institutional Abuse Policy 208 Section D, which outlines the agency is required by law to notify law enforcement and the Department of Justice (DOJ) of potential criminal violations involving children, alleged physical/sexual abuse or serious neglect of a client by a DSCYF employee, contractor or volunteer requires a multidisciplinary response. As written the policy does not include terminations for violations of sexual harassment policies.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Although a policy is not required, the agency relies on PREA 2.13 regarding staff disciplinary action. Revise PREA 2.13 policy to include that state staff is subject to "disciplinary sanctions up to and including termination for violating the agency sexual abuse and sexual harassment policies".
2. Sexual harassment violations are not included. Revise Institutional Abuse 208 policy to include terminations for violations of sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Child Sexual Abuse Protocol Memorandum of Understanding 2017 3. Delaware Children's Department Policy 313 Initial Background Checks and Subsequent Arrest and/or Allegations of Child Abuse/Neglect (Revised 12/15/16). 4. Department of Services for Children, Youth and Their Families Policy 305 Standards of Conduct Employees, Volunteers and Interns (Revised 4/9/2018). 5. Removal of Employees from the Workplace Policy 309 (Revised 11/1/12) 6. Delaware Children's Department Policy 208 Institutional Abuse (Revised 6/8/16). Interviews: 1. Superintendent Findings (by Provision): 115.377 (a): In the PAQ, the agency reported that agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies and be prohibited from contact with residents. In the past 12 months the facility reported that there had been no volunteers or contractors reported to law enforcement or licensing bodies for engaging in sexual abuse of residents. The agency relies on PREA Policy 2.13 Section III A and Section IV, C, 1, that outlines that volunteers and contractors are defined as departmental employees, and all staff are required to report any allegations and instances of non-consensual sexual acts, abusive sexual contact and sexual harassment to child abuse hotline 800-292-9582. The facility provided the Child Abuse Protocol Memorandum that outlines DFS must make an immediate report to the appropriate law enforcement jurisdiction and the Department of Justice for all civil offenses identified in the Sexual Abuse Protocol, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect. Agency Institutional Abuse Policy 208 Section D, outlines the agency is required by law to notify law enforcement and the Department of Justice (DOJ) of potential criminal violations involving children, alleged physical/sexual abuse or serious neglect of a client by a DSCYF employee, contractor or volunteer requires a multidisciplinary response. Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The evidence shows that contractor and volunteers are subject to reporting to law enforcement for engaging in sexual abuse, prohibited from contact with residents which was verified by policy, interviews, and file documentation. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.377 (b): In the PAQ, the agency reported that facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The facility relies on Policy 309 Removal of Employee from Workplace Section II, which outlines that the allegations of sexual abuse against a resident may lead to immediate removal of the employee from the workplace. As written, the policy does not include the immediate removal for allegations of sexual harassment by a contractor or volunteer. During an interview with the superintendent, when asked in the case of any violation of agency sexual abuse and sexual harassment policy by a contractor or volunteer does your facility take remedial measures and prohibit further contact with residents, staff stated the contact would be done and the contract unit would Limit contact within the facility or renegotiate the contract.

	Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required. Best Practice Recommendation: 1. Revise Policy 309 Removal of Employees from the workplace to include sexual harassment as an allegation as a remedial measure to prohibit any further contact with residents for violation of the agency's sexual abuse and sexual harassment policy.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Division of Youth Rehabilitative Services Professional Practices Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Intersex (LGBTQI) Policy 2.20 (Revised 3/5/19). 3. Stevenson House Detention Center Handbook Interviews: 1. Superintendent 2. PREA coordinator 3. PREA compliance manager 4. Medical and mental health staff 5. Discipline staff 6. Milford Police Department Onsite Review Observations: 1. Observations during onsite review of physical plant Findings (by Provision): 115.378 (a): In the PAQ, the agency reported that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding or criminal finding of guilt that the resident engaged in resident-on-resident sexual abuse. The agency reported in the past 12 months there was no administrative finding or criminal finding of guilt for resident-on-resident sexual abuse that occurred at the facility. The facility relies on PREA Policy 2.13 Section IV, C, 2, h-I, which outlines that sexual contact and harassment is prohibited, contacts shall be addressed in the behavioral management programs. As written the policy does not specifically state residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding or criminal finding of guilt that the resident engaged in resident-on-resident sexual abuse. Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department. The evidence shows that there were no administrative or criminal findings of guilt for resident-on-resident sexual abuse which was verified through documentation review, interviews, and policy. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.378 (b): In the PAQ, the facility reported if a disciplinary sanction for resident-on-resident sexual abuse results in isolation of a resident, policy requires that residents in isolation have daily access to large-muscle exercise, legally required educational programming, and special education services, shall receive daily visits from medical or mental health care clinician, and have access to other programs and work opportunities. In the PAQ, the facility reported there were no residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse that were denied access to large-muscle exercise, legally required programs, special education services, other programs, or work opportunities. Agency Policy LGBTQI 2.20 Section IV, E, 1, c, outlines that during a period of isolation DYRS staff shall not deny youth daily large-muscle exercise, legally required programming, or special education services. Youth in isolation shall receive daily visits from medical staff or behavioral health services clinician provider. The facility reported there are no work programs at

the facility.

During an interview with the superintendent, when asked what disciplinary sanctions are residents subject to following an administrative or criminal finding that a resident engaged in resident-on-resident sexual abuse, staff stated they would receive discipline through cognitive behavioral training (CBT) similar sanctions for similar offenses. When asked if the facility uses isolation as a sanction, staff indicated they do not use isolation as a sanction.

During an interview, the PREA coordinator, PREA compliance manager (PCM) and staff that perform screening confirmed that there is no isolation at the facility.

During the onsite review, the auditor went into all areas of the facility which included administration area, housing, classrooms, maintenance, food service, medical and mental health, library, gym, visiting area and did not observe any segregated housing units or isolation rooms. A review of 11 resident files did not reveal that residents were placed in isolation. The auditor's observation of the facility did not reveal any type of segregated housing or isolation room, cell or housing that would confirm that the facility isolates residents as outlined in this provision.

The evidence shows the facility does not isolate residents at the facility which was verified through interview, observation, and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (c):

In the PAQ, the facility reports that the disciplinary process considers whether a resident's mental disabilities or mental health contributed to his or her behavior when determining what sanction, if any, should be imposed.

During an interview with the superintendent, when asked is a mental disability or mental illness considered when determining sanctions, staff indicated that yes it would be considered.

During an interview with the disciplinary officer, when asked do you consider whether a resident has a mental disability or mental illness that may have contributed to the behavior when determining a sanction, staff indicated "yes". If they have IEP, we incorporate it in together.

A review of the 2019 and 2020 investigations reveals there were no allegations, administrative finding or criminal finding of guilt of resident-on-resident sexual abuse.

The evidence shows that a resident's disability and mental health is considered when determining sanctions which was verified through interviews, and investigation information.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (d):

In the PAQ, the facility reported that they offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, they do not require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, access to general programs and education is not conditional on participation.

During interviews with medical and mental health staff, when asked if the facility offers therapy, counseling or other interventions designed to address and correct underlying reasons or motivations for sexual abuse, does the facility offer to offending resident, staff indicated they would work with the victim as well as the perpetrator. When asked do you provide these services as a condition of access, staff stated they do not.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The evidence shows that the facility offers therapy without conditions of access which was verified through PAQ, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (e):

In the PAQ, the facility reports that agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

As outlined in the Stevenson House Detention Center Resident Handbook, the facility uses a Cognitive Behavioral Training

(CBT) approach to assist in changing inappropriate behaviors and to help youth examine belief and thinking patterns.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The evidence shows that the agency disciplines residents for sexual conduct with staff upon finding that the staff did not consent, which was verified by PAQ, resident handbook and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (f):

In the PAQ, the facility reported they prohibit disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Agency PREA Policy 2.13 Section IV C, 1, I, outlines that if a youth files a PREA grievance in bad faith, made a verbal report about a PREA matter in bad faith, the program may discipline a youth via the Cognitive Behavior Treatment (CBT) program a copy of the incident shall be kept on file by the PREA coordinator and PREA compliance manager. As written, the policy does not specifically outline that they prohibit disciplinary action for a report of sexual abuse made in “good faith” based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation

As outlined in the Stevenson House Detention Center Resident Handbook, the facility uses a Cognitive Behavioral Training (CBT) approach to assist in changing inappropriate behaviors and to help youth examine belief and thinking patterns.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The evidence shows that the agency prohibits disciplinary action for a report of sexual abuse made in good faith, which was verified by PAQ, and investigation records.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.378 (g):

In the PAQ, the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Agency PREA Policy 2.13 Section IV C, 1, h, outlines that consensual sexual activity between youth does not fall within the PREA definition or reporting procedures. However, sexual contact and sexual harassment is prohibited in all division programs and contracts. These contacts shall be addressed in the behavioral management programs.

Facility staff reported there were no allegations of sexual abuse or sexual harassment during the last 12 months. During an interview, Milford Police Department reported that there were no criminal cases of sexual abuse or sexual harassment reported to the department.

The evidence shows that the agency prohibits all sexual activity between residents which was verified by PAQ, policy and investigation records.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendations:

1. Although a policy is not required, revise PREA Policy 2.13 to include residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding or criminal finding of guilt that the resident engaged in resident-on-resident sexual abuse.
2. Although a policy is not required, revise PREA Policy 2.13 Section IV C, 1 I, to include they prohibit disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The current language mentions made in bad faith which is not consistent with the provision f.
3. Although a policy is not required, revise PREA Policy 2.13 Section IV, c, 2, to include that a resident may only be disciplined for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Department of Services for Children, Youth and Their Families Memorandum of Understanding between the Division of Prevention and Behavioral Health Services and the Division of Youth Rehabilitative Services. (6/28/19). Interviews: 1. Staff Responsible for Risk Screening 2. Medical and Mental Health Staff 3. Database Management Information Systems Specialist Findings (by Provision): 115.381 (a): In the PAQ, the agency reported that all residents at this facility who have disclosed any prior sexual victimization during a screening are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the PAQ, the facility reported in the past 12 months, all residents who have disclosed prior victimization during a screening were offered a follow-up meeting with a medical or mental health practitioner and medical and mental health staff maintain secondary materials documenting compliance. Staff that conduct risk screening are mental health staff, when asked if the screening indicate that a resident has experienced prior sexual victimization whether in an institutional setting or community, do you offer a follow-up meeting, staff stated “yes, we offer our initial services through PBH and provide them with materials if they request and SOARS”. The auditor reviewed 14 resident file records and intake documentation. In review, three out of 14 residents disclosed prior victimization. In review of four files only one file provided information that a resident that disclosed prior victimization was offered follow-up but was declined by the resident. The follow-up was offered immediately at the time of intake by a mental health staff. The evidence shows that the facility requires that a follow-up meeting is offered to residents that disclose prior victimization and the facility would conduct the follow-up within 14 days of the intake process, which was verified through PAQ, interview and documentation review. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.381 (b): In the PAQ, the agency reported that all residents who have ever previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. In the PAQ, the facility reported in the past 12 months, all residents who disclosed they previously perpetuated sexual abuse during screening and those residents were offered a follow-up meeting with a mental health practitioner mental health staff maintain secondary materials documenting compliance. It is noted that staff that conduct risk screening are also mental health staff, when asked if the screening indicates that a resident previously perpetuated sexual abuse, do you offer a follow-up meeting, staff stated “Yes, immediately we offer those services”. The auditor reviewed 14 resident files and intake documentation and determined that of the three residents that disclosed that they previously perpetuated sexual abuse during screening one resident was offered a follow up and declined. Although not required, three of the 14 files reviewed showed that resident’s that did not disclose that they previously perpetuated sexual abuse was also offered PREA counseling. However, those resident’s declined PREA counseling. The documentation provided appears to show that all residents are offered counseling. The auditor was not able to make this determination as eight of the 14 files provided did not contain this information. The evidence shows that the facility requires that a follow-up meeting is offered to residents that disclose they previously perpetuated sexual abuse and the facility would conduct the follow-up within 14 days which was verified through PAQ, interview and documentation review.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.381 (c):

In the PAQ, the agency reported that information related to sexual victimization or abusiveness that occurred in an institutional setting is not strictly limited to medical and mental health practitioners, information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

During an interview, the Information System Specialist/FOCUS liaison stated any cases for PREA comes into the intake portion of FOCUS and only the psychologist has access to the PREA risk assessment. Internal Affairs and the PREA coordinator have read only access. The superintendent and PREA compliance manager would not be able to see it. During the onsite review, the auditor was able to determine that access to information in FOCUS was granted based on the staff person's position.

The evidence shows that the agency has controlled the level of access that each staff has in the FOCUS database to control and protect sensitive information.

The evidence shows that information related to sexual victimization or abusiveness is limited and strictly controlled which was verified by PAQ and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.381 (d):

In the PAQ, the agency reported that the medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

During an interview with medical and mental health staff, when asked, do you obtain informed consent from residents before reporting about prior sexual victimization that did not occur in an institutional setting, staff stated "yes, I am a mandated reporter, even if they tell me not to I would report it

The auditor asked the staff to explain the informed consent process, staff stated". "Sexual health is 12 years old in Delaware, we have to get their consent". If they are under 16, they still require parental consent when they go to the clinic.

A review of the Consent for Diagnostic Procedures Division of Child Mental Health Services Intake and Assessment Services, outlines four conditions on which information about the client may be revealed to others which include the resident has vitaminized a child either sexually, physically or emotionally, they have been victimized by others, they plan to harm themselves or someone else. This document requires the consent of the resident and a responsible adult and witness.

The evidence shows that medical and mental health staff do obtain informed consent for residents over the age of 18. Residents at the facility are under the age of 18 and mental health and medical staff are mandated reporters.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Medical Emergencies Policy 7.3 (Effective 9/15/14). 2. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults (1/4/21). 3. Facility Coordinated Response Plan Interviews: 1. Medical and mental health staff 2. SANE Bayhealth Findings (by Provision): 115.382 (a-b): In the PAQ, the facility reported that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, services are determined by medical and mental health practitioners professional judgement. In the PAQ, the facility reported that medical and mental health staff maintain secondary materials that document the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually infection prophylaxis. The facility relies on policy 7.3 Medical emergencies, that outlines the physician in charge should be contacted immediately in the event of an emergency. If the youth is not transported to another facility or hospital the physician in charge shall be required to respond to emergencies. The policy provides an order of telephone contacts for emergency: 1. Ambulance or paramedic 2. Physician in charge 3. Facility superintendent or designee 4. Deputy directorParent, guardian or legal guardian. PREA Policy 2.13 outlines that all medical interventions for PREA related incidents in Kent and Sussex County will be referred to Milford Hospital. The auditor notes that Milford Hospital is now formally known as Bayhealth Hospital. The auditors interviewed a sexual assault nurse examiner (SANE) and manager at Bayhealth hospital regarding any services they would provide for victims at the facility. The forensic nurse manager stated they do offer SANE exams to victims of sexual abuse and victim advocate services and there is no cost to the victim. The agency has a Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) that DYRS youth that have been victims of sexual abuse be provided advocates for support during a forensic medical examination and emotional support services related to their victimization. During an interview, staff at SOARS confirmed that they have a memorandum of agreement with YRS to provide victim advocate for emotional support but have not had any contact with any residents at the facility or staff at the facility. When asked how does a resident contact your agency, the SOARS staff stated they would call (302)-655-3953 and after the prompts select extension 1 for the intake department. When asked do you accompany a victim during a forensic examination, staff stated “no” they would go to the hospital for someone in crisis, Staff stated they accompany victims through investigatory interview, emotional support, crisis intervention through telephone and maybe onsite. SOARS staff noted that during the COVID-19 pandemic they have been utilizing telehealth to communicate with victims. During an interview with medical and mental health staff, when asked do victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention, staff stated “Yes, they would contact those services immediately.” When asked is the nature and scope of these services determined by your professional judgement, staff stated “yes, we offer our initial services through PBH and provide them with materials if they request, and SOARS”. Review of the facilities coordinated response plan, the facility will request the assistance of law enforcement and a forensic

examination, make the appropriate triage with medica services, the youth will be transported to Bayhealth Hospital for a forensic examination and treatment.

The evidence shows that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services which was verified through PAQ, policy, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.382 (c):

In the PAQ, the agency reported that resident victims of sexual abuse while incarcerated are offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines Bayhealth Hospital employs forensic examination protocols in regards to sexual assaults of children in Delaware that are appropriate for youth, forensic exams are made available without cost to the youth, hospital attempts to make available to the victim a victim advocate from a rape crisis center, qualified agency staff member, qualified community based organization staff member with support through SANE process, investigative interviews, emotional support, crisis intervention, information and referrals.

The auditors interviewed a sexual assault nurse examiner (SANE) at Bayhealth Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams, counseling, victim advocate available and follow-up care offered by the hospital, There is 14 SANE examiners between three campuses that would be available within one hour and the cost is covered through the victim compensation fund, they provide counseling, follow-up care, medications to prevent sexually transmitted infections prophylaxis. The SANE examiner walked the auditor through the process of what they do in providing services to a sexual assault victim that would come into the hospital.

During an interview with medical and mental health staff, when asked are victims of sexual abuse while incarcerated offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, staff stated “Yes. Immediately offer those services, and they are reported and referred and documented in FOCUS.

The evidence shows that resident victims of sexual abuse while incarcerated are offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis which was verified thought MOU, PAQ, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.382 (d):

In the PAQ, the agency reported that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines forensic exams are made available without cost to the youth where evidentiary or medically appropriate.

The auditors interviewed a sexual assault nurse examiner (SANE) and manager at Bayhealth Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams, counseling, victim advocate available and follow-up care offered by the hospital and the cost is covered through the victim compensation fund.

The evidence shows that treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation which was verified through PAQ, MOU, and interviews.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. Division of Youth Rehabilitative Services Prisoner Rape Elimination Act (PREA) 2.13 (Revised 6/29/17). 2. Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults (1/4/21). 3. Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) and Website survivorsofabuse.org 4. Bayhealth Hospital website bayhealth.org 5. Investigation Records 6. State of Delaware, Department of Services for Children, Youth and Their Families Stevenson House Detention Center website http://kids.delaware.gov/yrs/stevenson Interviews: 1. Medical and mental health staff 2. SANE Bayhealth Hospital 3. Survivors of Abuse in Recovery, Inc. (SOARS) Findings (by Provision): 115.383 (a): In the PAQ, the facility reported they offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The facility relies on PREA Policy 2.13 E,1 (a), that outlines that all counseling services will be made available to all youth involved in non-consensual sex, abusive sexual contact or sexual harassment through Bayhealth Hospital for evaluation and treatment. During interviews with medical and mental health staff, when asked what does evaluation and treatment of residents who have been victimized entail, staff stated medically respond to take care of first aid, preserve the evidence, not let them near perpetrator and get them out as soon as we can. The auditors interviewed a sexual assault nurse examiner (SANE) and manager at Bayhealth Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams, counseling, victim advocate available and follow-up care offered by the hospital and there is no cost to the victim. The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit. The evidence shows that medical and mental health services evaluation and treatment is offered for residents that have been victimized by sexual abuse. Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required. 115.383 (b): In the PAQ, the facility reported that evaluation and treatment for victims include follow-up services, treatment plans, and when necessary referrals for continued care following their transfer to another facility or release from custody. The facility relies on PREA Policy 2.13 that outlines that the Division of Prevention and Behavioral Health (DPBH) psychologist or the DYRS contracted medical provider will provide follow-up care while the youth remain in custody and for release and discharge. In addition to counseling services provided by DPBH, all youth shall be made aware of community agencies. The agency has a Memorandum of Agreement between the Division of Youth Rehabilitative Services and Survivors of Abuse in Recovery, Inc. (SOARS) that DYRS youth that have been victims of sexual abuse be provided advocates for support during a forensic medical examination and emotional support services related to their victimization. During an interview, staff at SOARS confirmed that they have a memorandum of agreement with the facility to provide victim advocate for emotional support, crisis intervention and individual therapy but have not had any contact with any residents at the facility.

The auditors interviewed a sexual assault nurse examiner (SANE) at Bayhealth Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams, counseling, victim advocate available and follow-up care offered by the hospital and there is no cost to the victim and the cost is covered through the victim compensation fund.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (c):

In the PAQ, the facility reported they provide victims with medical and mental health services consistent with the community level of care.

During interviews with medical and mental health staff, when asked are medical and mental health services consistent with community level of care, staff stated “yes, I would say it is better”.

The auditor reviewed the agency’s website for the facility, the facility states certified providers offer medical, dental and psychological services.

During interviews with residents, no resident stated they had reported sexual abuse at the facility. The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (d-e):

In the PAQ, the facility reported that female victims of sexual abusive vaginal penetration while incarcerated are offered pregnancy tests.

In the PAQ, the facility reported that if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information, timely access to all lawful pregnancy related medical services.

During interviews with medical and mental health staff, when asked if pregnancy results from sexual abuse while incarcerated, are victims given timely information and access to all lawful pregnancy related services, staff stated “100%. If they do decide, we give them the nurse family partnership program in the community. “As soon as they make their decision. I make sure they have the information to read and instantly make the referral while they are sitting there”.

The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit. At the time of the onsite audit, no female residents were housed at the facility.

The auditors interviewed a sexual assault nurse examiner (SANE) at Bayhealth Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams which can take anywhere from four to six hours, prophylaxis treatment, pregnancy testing, counseling, victim advocate, follow-up care offered by the hospital. There are 14 SANE examiners between three campuses that would be available within one hour and the cost is covered through the victim compensation fund.

The evidence shows that female victims would receive pregnancy test and timely access and information which was verified through PAQ, and interviews. At the time of the onsite audit, no female residents were housed at the facility.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (f):

In the PAQ, the facility reported that resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

The auditors interviewed a sexual assault nurse examiner (SANE) at Bayhealth Hospital regarding any services they would provide for victims at the facility. The forensic nurse stated they do provide SANE exams which can take anywhere from four to six hours, prophylaxis treatment, pregnancy testing, counseling, victim advocate, follow-up care offered by the hospital, follow-up care medications to prevent sexually transmitted infections.

The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (g):

In the PAQ, the facility reported that treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The facility provided Department of Services for Children, Youth and Their Families Affirmation of Compliance with Forensic Examinations Standards for Sexual Assaults that outlines Bayhealth Hospital employs forensic examination protocols in regards to sexual assaults of children in Delaware that are appropriate for youth, forensic exams are made available without cost to the youth, hospital attempts to make available to the victim a victim advocate from a rape crisis center, qualified agency staff member, qualified community based organization staff member with support through SANE process, investigative interviews, emotional support, crisis intervention, information and referrals.

The auditors interviewed a sexual assault nurse examiner (SANE) at Bayhealth Hospital regarding any services they would provide for victims at the facility, staff stated there is no cost to the victim, costs are covered through the victim compensation fund.

During interviews with residents, no resident stated they had reported sexual abuse at the facility. The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

115.383 (h):

In the PAQ, the facility reported that the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

During interviews with medical and mental health staff, when asked, do you conduct a mental health evaluation of all known resident-on-resident abusers and offer treatment if appropriate, staff stated “yes, we would do that in a day if not the same day”.

During interviews with residents, no resident stated they had reported sexual abuse at the facility. The facility reported that there were no sexual abuse allegations at the facility during the last 12 months preceding the onsite audit.

Based upon this analysis, the facility is substantially compliant with this provision and no corrective action is required.

Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Best Practice Recommendation:

1. Although a policy is not required, revise the PREA policy Section IV E victim services, to include that treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13IV.D.4.a-b 2. DYRS Policy 2.13IV.D.4.f-h 3. Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes Form 4. Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes Form 2/13/2020 (Mock) 5. Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes Form 1/21/2021 (Mock) Interviews: 1. Superintendent 2. PREA compliance manager 3. Incident Review Team Member (Assistant Superintendent) Findings (by Provision): 115.386(a)-1-2: In the DYRS Policy 2.13.IV.D.4.h, there is mention of an internal administrative review. It further states that the administrative unit is to identify two supervisory level staff that have received training to assist this level of incident review. After closer examination, the auditor is interpreting that the internal administrative review as an internal administrative investigation which would be conducted by investigators that have specialized training. Further, the investigators would provide evidence and findings to the administrative team. There were no sexual abuse investigations in the past 12 months to corroborate this practice. To review the facility's practice and gauge compliance, the auditor reviewed copies of two mock treatment team meetings' minutes which were provided during the onsite audit by the superintendent. Within DYRS Policy 2.13, there is a section that details that in the absence of an incident of a sexual abuse or sexual harassment allegation the facility is to conduct a mock incident review meeting on an annual basis. It was explained by the superintendent that the incident review meeting would be conducted during a treatment team meeting. For both mock incident reviews, the facility uploaded the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes Form to the supplemental files in the OAS. The forms contained all the information that was contained on the meeting minutes. The facility meets substantial compliance in this provision. 115.386(b)-1 DYRS Policy 2.13IV.D. a-b states that the program or facility will conduct a sexual abuse incident review within thirty days of the report of the independent Institutional Abuse investigation or when directed if the official investigation extends beyond 45 days. All extensions must be approved by the division director. Since the documentation was of mock incidents, the date of completion could not be determined. On the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes Form, it states the form is to be completed 30 days after the PREA incident. The facility meets substantial compliance in this provision. 115.386(c)-1 Contained on the mock Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes form, there were several individuals participating on the sexual abuse review team. They included the superintendent, assistant superintendent, PREA compliance manager, three YCR supervisors, a YRC III, medical staff, and mental health staff. Representing the upper management was the PREA compliance manager, superintendent, and the assistant superintendent. The facility PREA investigator was identified on the list as the assistant superintendent. The team utilized the input from medical and a mental health practitioner on the team. During the interview, the superintendent was aware of the participants on the incident review team. The facility meets substantial compliance in this provision. 115.386(d)-1 The report of the sexual review team is documented on the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes form. The form includes the following information: • Reportable Incident Date • Facility

- PREA Type: Resident on Staff or Resident on Resident
- Type of Sexual Violence
- Incident Description
- Substantiated or Unsubstantiated
- Review Team Members
- As a result of the allegation, is there a need for policy or practice change that would better prevent, detect, or respond to sexual abuse? If yes, what needs to be changed?
- Was the incident motivated by any of the below (check all that apply)
- Were there any physical barriers where the alleged incident occurred that would enable abuse? If yes note under (6) Recommendations
- What was the staffing level at the time of the incident? Was the staffing level adequate? If no, explain:
- Was monitoring technology adequate for that area? If it was not adequate, what is needed? (explain)
- Findings of Team
- Final Recommendation
- Facility Head Comments
- Facility Head Signature and Date

The completed form is to be copied to the deputy director, PREA coordinator, PREA compliance manager, and the management analyst- Office of the Director

The form contains all required information required by PREA Standard 115.386(d) which includes the consideration for policy or practice to better prevent, detect, or respond to sexual abuse. It considers if the allegation was motivated by race, ethnicity, gender identity, LGBQTI, status or perceived status, gang affiliation, or other group dynamics. The review team examines the area to assess if there were any physical barriers, and they assess the staffing levels. The team also reviews the monitoring equipment. Lastly, the team completes the report and submits to the deputy director, PREA coordinator, PREA compliance manager, and the management analyst.

During the interviews, the auditor found that the superintendent and the assistant superintendent both participated on the incident review team. Both confirmed that factors are considered of the motivation for the allegation of sexual abuse. Additionally, there is an assessment of staffing levels, physical barriers, and the monitoring technology. The facility meets substantial compliance in this provision.

115.386(e)-1

Located on the Sexual Abuse Incident Review of Substantiated or Unsubstantiated Outcomes, there is a section on the form with the findings and the final recommendations. Based on the mock sexual abuse incident review, the findings of the team and the final recommendation was documented. Due to the incidents being mock, the recommendations were not implemented. The facility meets substantial compliance in this provision.

The evidence shows that the facility does have a sexual abuse incident team, and they utilize the Sexual Abuse Incident Review of Substantiated and Unsubstantiated Outcomes form to document the review. The sexual abuse team has upper-level management and input from both medical and mental health. The review team has an investigator participating. The established form lists variables to consider when reviewing allegations of sexual abuse. Lastly, the facility considers recommendations to implement or documents its reasons for not doing so. The facility is substantially compliant with this standard and there are no corrective actions required.

Best Practice Recommendations:

1. DYRS Policy 2.13IV.D.4.h revise language add sexual abuse, sexual harassment, and retaliation; change internal administrative review to internal administrative investigation; efficient time frame should be a set time; Clarify the following all issues regarding protection and/or prevention retaliation shall also apply to harassment allegations. Include that investigators must have training in investigating sexual abuse in confinement.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.F.1-4 2. DYRS Policy 2.13 Attachment A 3. DYSR Policy 2.13 Attachment B 4. DYRS Policy 2.13 Attachment C 5. DYRS Policy 2.13 Attachment D 6. DYRS Policy 2.13.IV.C.1.c 7. Excel spreadsheet containing the incidents of sexual abuse and sexual harassment investigations from the private facilities in which DYRS contracts for confinement of its residents 8. Survey of Sexual Violence for 2019 9. https://kids.delaware.gov/pdfs_archive/prea/SSV-2019.pdf Interviews: 1. Management analyst Findings (by Provision): 115.387 (a)-1: DYRS Policy 2.13.IV.F.1-4 requires data collection utilizing a standardized instrument and a set of definitions. The 4 attachments to the policy are the forms used to collect the required information. • DYRS Policy 2.13 Attachment A- Sexual Violence Incident Form • DYSR Policy 2.13 Attachment B-Sexual Violence Incident Form: Victim • DYRS Policy 2.13 Attachment C-Sexual Violence Incident Form: Youth Perpetrator • DYRS Policy 2.13 Attachment D-Sexual Violence Incident Form: Adult Perpetrator Based on the sexual abuse investigation in 2019 and the review of the other DYRS facilities investigative files, the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The agency does substantially meet compliance in this provision. 115.388(b)-1 According to DYRS Policy 2.13.IV.F.4, the management analyst III will provide a quarterly report to the deputy director to ensure outcome information is accurate and current. Annually, the facility aggregates the incident-based sexual abuse data in preparation for the submission of the Survey of Sexual Violence conducted by the Department of Justice. The agency does substantially meet compliance in this provision. 115.387(c)-1 Review of the DYRS Policy 2.13 attachments are in alignment with the information necessary to complete the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The agency does substantially meet compliance in this provision. 115.387(d)-1 DYRS Policy 2.13.IV.F.2-3 states that the administrators are responsible for providing the internal investigation outcome for data collection. The deputy director will be responsible for reporting IA and/or criminal investigation outcomes for data collection. The policy details the agency shall maintain, review, and collect data from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The agency does substantially meet compliance in this provision. 115.387(e)-1 Cited in the mandatory reporting section of DYRS Policy 2.13.IV.C.1.c contracted programs are responsible for reporting according to their contract and operating guidelines. In the supplemental files of the OAS, the management analyst provided the auditor an Excel spreadsheet containing the incidents of sexual abuse and sexual harassment investigations from the private facilities in which DYRS contracts for confinement of its residents. The agency does substantially meet compliance in

	this provision. 115.387(f) Provided on the agency's website is a copy of the report Survey of Sexual Violence for 2019. The report was submitted prior to June 30, 2020 by the management analyst. The agency does substantially meet compliance in this provision. The evidence shows that the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under direct control using a standardized instrument and set of definitions. The agency has demonstrated it annually aggregates the incidence based sexual abuse data. The data contains the minimum of the information to complete the Survey of Sexual Violence. The agency collects information from incident-based documents, reports, investigation files, and sexual abuse incident reviews. The agency collects information from the contacted facilities that contract with DYRS for the placement of residents. Based upon this analysis, the facility is substantially compliant with this standard. Best Practices Recommendations: 1. Revise DYRS Policy 2.13.IV.C.1.c with the addition of sexual abuse and sexual harassment

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.F.1-5 2. https://kids.delaware.gov/yrs/prea-reports.shtml 3. DYRS Annual Report CY-2019 Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report Interviews: 1. Director 12-15-2020 2. Deputy Director 2-15-2021 3. PREA coordinator 4. PREA compliance manager 5. Director's Team Meeting Minutes 8/7/20- Zoom Meeting Findings (by Provision): 115.388(a): DYRS Policy 2.13.IV.F.5.a-d requires that an annual report shall be readily available to the public through its website. All information must receive prior approval by the division director before website posting. The annual report shall include the following: a. Any findings and corrective actions for all allegations identified by facility. b. A comparison of the current year's data and corrective actions with those from prior years c. An assessment of the Division's progress in addressing sexual abuse. d. The Division may redact specific material from reports when a publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. Review of the director's team meeting minutes from 8/7/20 reveal there is time devoted by DYRS to discuss information obtained from the data collected. During the meeting, there was an opportunity to discuss staffing plans and video monitoring system needs or concerns. During inquiry of the director (12/15/2020), the auditor asked how the agency utilizes incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training. The deputy director responded that the information assists in making adjustments in staffing and monitoring of residents. Additionally, it could flag an individual that is repeatedly accused of sexual harassment or sexual abuse. It was verified by the PREA coordinator that the agency does review the data collected to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, training as well as address any corrective action. It was further shared that the data and documents related to PREA are maintained with the management analyst under a two-lock system. Lastly, there was confirmation that a report was generated and placed on the agency's website. The PREA compliance manager also confirmed that the agency reviews data collected for sexual harassment and sexual abuse. During the onsite audit at Stevenson House Detention Center, the director was unavailable. The designee for agency head was the deputy director. The deputy director informed the auditors that there is a collaboration with the Professional Standards Unit in reviewing the incident based sexual abuse and sexual harassment data. Trends are evaluated within the facilities that are impacting sexual abuse and sexual harassment. The agency does substantially meet compliance in this provision. 115.388(b)-1-2 The DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report) summarizes and compares the aggregated information of sexual harassment and sexual abuse received from both DYRS operated facilities and contracted facilities. Included on the report is the data analysis which details corrective actions. Found within the report is an assessment of the agency's progress in addressing sexual abuse. The

	agency does substantially meet compliance in this provision. 115.388(c)-1-3 The DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report) can be found on the agency website https://kids.delaware.gov/yrs/prea-reports.shtml, and the report is signed by the director of DYRS. The director of DYRS stated on 12/15/2020 that he approves annual reports that are written pursuant to PREA Standard 115.388. The agency does substantially meet compliance in this provision. 115.388(d)-1-2 There were no redactions in the DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report). A redaction clause was not necessary. The PREA compliance manager stated that redactions would include personal information. The auditor determined that the report did not require personal information so there was no need for redaction. The agency substantially does meet compliance in this provision. The evidence shows that the agency reviews data collected and aggregates to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies and training as well as corrective action. This information is developed into a report titled the DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report). The report is approved by the director and made public annually on the agency website. There were no redactions to the report. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 2.13.IV.F.6-7 2. DYRS Policy 2.13.IV.F.5 3. The DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report) 4. https://kids.delaware.gov/yrs/prea-reports.shtml Interviews: 1. Management Analyst 2. PREA Coordinator Site Review: 1. Management Analyst's Office 12/16/2021 Findings (by Provision): 115.389 (a)-1: According to DYRS Policy 2.13.IV.F.6 all data collected throughout the division on PREA allegations and all associated reports, shall be securely stored by the management analyst using a double lock system. The PREA compliance manager further confirmed that all PREA related allegations and reports are maintained in a double lock system in the management analyst office. During the interview with the management analyst on 12/16/2020, the auditor toured the office of the management analyst to verify the location and security of documents which were double locked. According to the management analyst on 2/15/2021, there has been no changes in the storage of the documents pertaining to allegations of sexual abuse and sexual harassment. The agency substantially meets compliance in this provision. 115.389(b)-1 The DYRS Annual Report CY-2019 (Delaware Division of Youth Rehabilitative Services Prison Rape Elimination Act 2019 Annual Report) summarizes and compares the aggregated information of sexual harassment and sexual abuse received from both DYRS operated facilities and contracted facilities. The agency's practice includes the aggregated sexual abuse data from DYRS operated facilities and contracted facilities, but there is no policy that requires this action. This information is made public at https://kids.delaware.gov/yrs/prea-reports.shtml. The agency substantially meets compliance in this provision. 115.389(c)-1 Review of the agency website the auditor determined that DYRS has shown a practice of removing all personal identifiers from reports released on the agency website. During the interview on 2/15/2021, the auditor was told by PREA coordinator that personal information would be redacted from reports. The agency substantially meets compliance in this provision. 115.389(d)-1 DYRS Policy 213.IV.F.7 requires that all data collected throughout the division on PREA allegations and all associated reports will be retained for no less that 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. Review of documents maintained indicated that information is maintained for no less than 10 years. The agency substantially meets compliance in this provision. The evidence shows that the agency ensures that incident based, and aggregate data are securely retained. The agency has made public both DYRS operated and contracted facilities aggregated sexual abuse data available to the public annually through the website. The agency has insured that there are no personal identifiers on data released to the public, and sexual abuse and sexual harassment documents are maintained for no less than 10 years. Based upon this analysis, the agency is substantially compliant with this standard and no corrective action is required. Best Practice Recommendations:

	1. Add to Policy 2.13.IV.F.5 requirements of 115.389(b)-1

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Policy 5.24 2. DYRS Policy 5.6 3. Contract Excel Spreadsheet 4. DSCYF Website 5. Review of contracted facilities PREA final reports 6. https://kids.delaware.gov/yrs/prea-reports.shtml Interviews: 1. Contract Manager 2/15/2021 2. Mailroom Staff 2/16/2021 Findings (by Provision): 115.401 (a)-1: During the prior three-year audit period, DYRS has ensured that DYRS operated facilities and contracted facilities were audited. The only exception was for the Residential Cottages' PREA audit which was rescheduled due to the Covid-19 Pandemic. During the interview with the contract manager, it was confirmed that all contracted facilities had completed the PREA final reports. In the PAQ, the contract manager provided an Excel spreadsheet with all completed final PREA report dates of contracted facilities. During the interview with the contract manager, the auditor inquired if there were any changes since the upload into the OAS. Based on the information provided, the auditor determined that all contracted facilities had provided a final PREA report. For those facilities that did not have a website, the contract manager provided the copy of the facilities PREA final reports to the auditors. Listed below are the DYRS operated facilities PREA final reports along with the cycle and year completed. This information is also obtainable on the DYRS website. https://kids.delaware.gov/yrs/prea-reports.shtml Ferris School Year 3 Cycle 2 Ferris School Year 3 Cycle 1 New Castle County Detention Center Year 3 Cycle 2 New Castle County Detention Center Year 3 Cycle 1 Residential Cottages Year 1 Cycle 2 Residential Cottages Year 3 Cycle1 Residential Cottages Interim Stevenson House Detention Center Year 2 Cycle 2 Stevenson House Detention Center Year 3 Cycle1 DYRS substantially meets compliance with this provision. 115.401(b)-1 This is the second year of the current audit cycle, and the agency was not able to ensure that at least one-third of each facility type operated by the agency was audited in the first year of the audit cycle due to the Covid-19 Pandemic. DYRS substantially meets compliance with this provision.

115.401(h)-1

DYRS allowed full access to, and the ability to observe, all areas of the Stevenson House Detention Center. The auditors were given full access to all areas of the facility. There were actively Covid diagnosed youth in the facility. DYRS substantially meets compliance with this provision.

115.401(i)-1

The auditor was permitted to request and receive copies of any relevant documents, including electronically stored information from agency's databases and hardcopy files. All requests for documents were fulfilled in a timely manner. DYRS substantially meets compliance with this provision.

115.401(m)-1

In accordance with DYRS Policy 5.24 and DYRS Policy 5.6, youth are permitted to send information and correspondence to the auditor in the same manner as legal correspondence. Based on information provided by staff that handles resident mail, all mail is opened, searched, and read and it is not necessarily handled in a confidential manner including legal correspondence. Outgoing mail is not sealed prior to being handled by staff. During all phases of the audit, the lead auditor received no correspondence from youth or staff at Stevenson House Detention Center. The mail handling policy and the information obtained during the interview regarding the handling of the mail were in conflict. This concern has been further detailed in PREA Standard 115.353 as a corrective action.

DYRS has ensured that agency operated, and contracted facilities have been audited at least once. During the first year of the audit cycle, the Residential Cottages were not audited due to the Covid-19 Pandemic. The auditors were granted full access to all areas of the Stevenson House Detention Center. The auditors were permitted to request and receive copies of any relevant documents including electronic stored information on databases. The auditors attest that they were permitted to conduct private interviews with residents. The residents were permitted to send correspondence to the auditor in the same manner as communication with legal counsel. It was determined that mail is not handled in a confidential manner. DYRS substantially meets compliance with this provision.

Based on this analyst the Stevenson House Detention Center is substantially in compliance with Standard 115.401. There is no corrective action at this time. The auditor's concern regarding confidentiality in the handling of mail is detailed in PREA Standard 115.353 as a corrective action.

Best Practice Recommendations:

1. Create a correspondence list of persons, agencies, and correspondences that are not opened and can be sealed in order for the residents to have confidential correspondence equivalent of legal correspondence.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents: 1. DYRS Final Audit Reports 2. https://kids.delaware.gov/yrs/prea-reports.shtml Findings (by Provision): 115.403 (f): The auditor located all the division operated facilities final PREA reports on the agency's website https://kids.delaware.gov/yrs/prea-reports.shtml. All audits for the past three years is available on the website. The only exception is the Residential Cottages which was impacted by the Covid-19 Pandemic. At this time, the Residential Cottages audit is pending. The evidence shows that DYRS publishes all PREA final reports for division operated facilities on the agency's website https://kids.delaware.gov/yrs/prea-reports.shtml. Based upon this analysis, the facility is substantially compliant with this standard and no corrective action is required.

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	yes
115.312 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	yes

115.313 (a)	Supervision and monitoring	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes

115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	no
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)	yes
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes

115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	na
115.315 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.315 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

115.316 (a)	Residents with disabilities and residents who are limited English proficient	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes

115.317 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.318 (a)	**Upgrades to facilities and technologies**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	na
115.318 (b)	**Upgrades to facilities and technologies**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.321 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes

115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is not responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	yes

115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes

115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	no
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.332 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes

115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.335 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes

115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	no
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	**Placement of residents**	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	na
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	na
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes

115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	no
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes
115.352 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	na
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	na

115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
115.352 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	na
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na
115.352 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	na
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	na

115.352 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
115.352 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	na
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	no
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	no
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	no
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes

115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes

115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	yes
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes
115.362 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.363 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.364 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.364 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.365 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	no
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes

115.367 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	no
115.371 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes

115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371 (f)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.371 (h)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes

115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes
115.373 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes

115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.376 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.378 (a)	**Interventions and disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes

115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes

115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	
	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes
115.382 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	yes
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	yes

115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes

115.387 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	yes
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	yes
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	yes
115.388 (c)	**Data review for corrective action**	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes

115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	no
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes